State Title V Block Grant Narrative

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Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (http://www.mchdata.net).

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1.4 OVERVIEW OF THE STATE

Minnesota derives its name from the Dakota Indian word *minisota* meaning "water tinted like the sky", which was what early Native Americans called what is now known as the Minnesota River[1]. It is a medium-sized state encompassing slightly more than 84,000 square miles, located in the north central part of the United States, and bordered by the Canadian provinces of Ontario and Manitoba on its north, Lake Superior and Wisconsin on the east, Iowa on its south and North and South Dakota on the west. Also called "Land of 10,000 Lakes", it is well-known for its scenic, cultural and recreational resources. With all the benefits that accrue from such amenities, plus a strong economy and a highly employable work force, Minnesota consistently ranks as one of the most desirable and healthy states in which to live and work.

Created as the Territory of Minnesota in 1849 and admitted to the Union as the 32nd state in May of 1858, the state's earliest economies centered on its natural resources of farming, logging and mining. Today, while it remains a major agricultural producer both nationally and internationally, Minnesota's economy is driven primarily by service sector industries such as healthcare; manufacturing (including computers, printing and publishing); financing, insurance and real estate; and wholesale and retail trade.

The workforce sustaining this economy comes from an estimated 1999 population of 4,775,508, making Minnesota the 21st most populous state in the nation.[2] Seventy percent of this population lives in the state's metropolitan statistical areas (MSAs), which, —as illustrated by the map in Appendix B- include Minneapolis-St. Paul, Duluth-(Superior, WI), St. Cloud, Rochester, (Fargo, ND)-Moorhead, (Grand Forks, ND)-East Grand Forks, and (La Crosse, WI)-Houston County.[3] Residents of the seven-county, Minneapolis-St. Paul, metropolitan area now comprise 53 percent of the state's population and two-thirds of the statewide population increase of 406,599 that occurred between 1990 and 1998 took place in this seven-county, Twin Cities metro area.[4] Eleven Minnesota counties and two Wisconsin counties constitute the Minneapolis-St. Paul MSA and three-fourths of the 1990-98 statewide increase of 406,599 occurred in this MSA, which means that almost 58 percent of the Minnesota's population lives in these eleven counties.[5] A total of eleven counties in the state had an increase of 10,000 or more people between 1990 and 1998 and nine of them are counties within the Minneapolis-St. Paul MSA.[6] The state's population increase in the last decade is clearly concentrating itself in these eleven counties. There are also counties that lost population between 1990 and 1998. Twenty-one of the state's 87 counties lost population during that time frame and nine of them lost at least 3 percent of their respective 1990 population[7].

With two exceptions, these nine counties were all located along the state's western border.[8] (See Appendix B.2 Minnesota's County Map).

A. Characteristics Defining The Needs Of The Entire State Population

The health needs of any state's entire population can be described from a limited number of broad-based themes. For Minnesota, in the year 2000, the dimensions (especially from a MCH perspective) that best characterize the needs of all Minnesota citizens include a changing statewide demographic profile, poverty status (especially of children), urban/rural population distribution, and disparities in health status among the state's various populations.

1. Changing Demographic Profile

Demographically, Minnesota had a relatively homogenous racial and ethnic population for most of the twentieth century. This is changing, and although the absolute numbers of populations of color are small, the rate of change is not. And, as with other states, Minnesota also faces other significant demographic changes such as the aging of its population, concentration of various populations in its metropolitan areas, and rising dependency ratios (elderly and children as a ratio to the working-age population). These changes will impact not only the need for and the type of healthcare, but will also affect housing, education, business, commerce, employers and social services.

A few projections, and specific examples or implications for state and local public health agencies and their MCH programs, of the state's changing demographics include:[9]

- An increase in the median age from 32.5 to 41.3 between 1990 and 2025 (it rose to 35.2 in 1998, according to the US Census Bureau). Corollary projections include substantial growth in the 45-64 population, significant growth in elderly age groups and a slight drop in the child population 0-14. While the total number of children 19 and under increased from 1,298,377 to 1,401,305 between 1990 and 1998, the number of children 4 and under decreased from 341,315 to 317,381 in the same time period.[10]
- There is a projected substantial increase in all populations of color between 1990 and 2020. Corollary projections include significant differences in the median age among Caucasians, African Americans, American Indians and Asian/Pacific Islanders. Most non-white racial groups will make up a larger percentage of youth 14 and under than they will of other age-cohorts. For example, state

demographer projections for the year 2005 estimate that 14.2 percent of youth 14 and under will come from non-white racial groups compared to 8.9 percent of the total population and 3.1 percent of those 65 and older.[11] The number of minority students enrolled in K-12 during the 1988-89 school year was 62,619 or 8.6 percent of all students; a decade later during the 1998-99 school year this number rose to 129,774 or 15.2 percent of all students.[12] The school enrollment data do not distinguish between white Hispanic and black Hispanic, so its calculation should be greater than that of the state demographer cited above.

- International migration added about 7,000 individuals to the state's population each year from 1990 through 1994.[13] In 1995 this number increased to slightly more than 8,000; and in 1996, slightly less than 9,000 immigrants from at least 90 different countries settled in Minnesota.[14] Not only are the number of immigrants increasing, but the percentage of immigrants who are refugees compared to the U.S. total is quite high. The Minnesota Planning Agency estimates that refugees constituted 42 percent (compared to a nationwide figure of 15 percent) of all state immigrants in 1996.[15] Large numbers of refugees from Southeast Asia arrived in Minnesota in the late 1970's and early 1980's, and again in the mid-90's. Minnesota schools report 20,371 enrolled students in the 1999-2000 school year from homes where Hmong is spoken (Minnesota Planning, B.J. Ronningen, email communication, February 25, 2000). Some state analysts speculate that half of all Somali immigrants in the U.S. reside in Minnesota.[16] A third example of the influence of international immigration on the state's demographics is the three-fold increase between 1990 and 1999 (from 20,231 to 55,888) of the number of school children living in a household where a language other than English was spoken (Ronningen, February 25, 2000). At least 67 different languages are spoken in these students' homes (Ronningen).

2. Poverty

Timely, accurate and meaningful data on poverty, especially for children, are difficult to obtain. According to estimates from the federal census bureau released in February of 1999, the number of Minnesota children under 18 years of age living in poverty during 1995 was estimated at 11.7 percent for a total of 148,434 children and the number of children under 5 living in poverty was estimated at 13.0 percent of that population or 42,729 children.[17] Percentage-wise these rates are significantly higher,

particularly for children under 5, than the estimate of 8.7 percent of all Minnesotans living in poverty.[18]

MinnesotaCare is the state's subsidized health insurance program that is administered by the Minnesota Department of Human Services. Internal studies by that agency for state fiscal year 1997 indicate children represented almost 55 percent of all enrollees (99,555) in this program and that 91 percent of these children were from families whose income level was 200 percent or less of the applicable federal poverty guideline and 71 percent of the children were from families whose income was at or less than 150 percent of the applicable Federal Poverty Guidelines.[19]

The Survey of Consumer Finances is a well-respected triennial survey of family finances sponsored by the Board of Governors of the Federal Reserve. While it is national data that does not provide state-specific information, its income-specific data is descriptive of MCH program populations and its latest survey, conducted in 1999, was published in 2000. In terms of constant 1998 dollars, the data indicated that both mean and median before-tax income increased for all U.S. families between 1989 and 1998 and also between 1995 and 1998. However, for those families earning less than $10,000, both the mean and median before-tax income declined between 1989 and 1998 and remained unchanged between 1995 and 1998.[20] Trends for families in the $10-24,999 range are more mixed: both the median and mean before-tax income increased between 1989 and 1998, but both declined between 1995 and 1998.[21] The study did indicate that the proportion of families comprising the survey sample whose family income was less than $24, 999 dropped from 39.0 percent in 1989 to 37.4 percent in 1998 and the study did not measure the potential impact of eligibility for the federal Earned Income Tax Credit which would improve family finances for low-income families. However, these are the income ranges of populations served by MCH programs of local public health agencies and the Federal Reserve study suggests no appreciable change in family poverty status, and thus by implication, the numbers of children living in poverty from the 1999 estimates by the federal census bureau which were based on 1995 data.

A fourth and more direct measure of childhood poverty in Minnesota is the level of participation of public school students in the state's K-12 free school lunch program. Free school lunches are available to children in families whose income is at or less than 130 percent of the applicable federal poverty level and reduced-price school lunches are available to children in families whose income is at or less than 185 percent of the applicable federal poverty level. The number of children eligible for free school lunches has risen from 133,204 or 17.4 percent of K-12 students in the 1991-92 school year to 163,147 (19.3 percent) in the 1997-98 school year; 160,547 (18.95 percent) in the 1998-99 school year; and 156, 212 (18.5 percent) in the 1999-00 school year.[22] The number of students eligible for reduced-price school lunch rose

from 45,421 (5.9 percent of the K-12 population) in the 1991-92 school year to 62,805 (7.4 percent) in the 1998-99 school year and 63,542 (7.5 percent) in the 1999-00 school year. [23] In both the Minneapolis and the St. Paul school districts, the number of K-12 students eligible for the free school lunch program is over 50 percent for the 1998-99 and 1999-00 school years.

3. Urban/Rural Contrasts

Rural Minnesota is characterized by low population densities, a greater proportion of the elderly and lower income levels and these differences become further complicated and defined by factors such as geography, transportation, the state's size and its climate.

The Minnesota Planning Agency estimates 28 percent of Minnesotans live in rural areas.[24] Rural population is defined as the population not living in an urbanized area which is defined as the six central cities of Minneapolis, St. Paul, Duluth, St. Cloud, Moorhead, and Rochester and "their densely settled suburbs" plus people living in cities of 2,500 or more located outside of an urbanized area.[25] This definition is similar to the definition of rural Minnesota in the health insurance study described below.

In a recently released report on health insurance in Minnesota, the report's authors divided the state into three parts: Minnesota counties of the Minneapolis-St. Paul MSA (Twin Cities Metro), all other Minnesota counties in a MSA (other Metro), and the remaining non-MSA counties (non-Metro). The non-MSA counties closely parallel, but are not identical to, the state planning agency's definition of rural Minnesota. The study concludes that "a larger portion of the population in rural counties than in metro counties are covered by Medicare"; viz. 15.0 percent in non-metro versus 11.8 percent in other metro counties and 10.5 percent in Twin Cities Metro counties[26]. This greater percentage of the population that is covered by Medicare means that rural health care providers (and also the communities in which they live) are more dependent on Medicare revenues than their colleagues in metro areas. This pattern also appears to hold for other publicly funded programs such as the state's Medicaid program and its MinnesotaCare program. These higher rates of Medicare enrollment and of poverty are significant to the rural population because Minnesota is a state where health and social services are delivered and partially financed through county political structures. In addition, significantly larger proportions of metro residents have group or employer-based insurance than do rural residents (73.3 vs. 59.1 percent) and more rural residents have individual coverage than do metro residents (6.6 vs. 3.7 percent).[27]

The northwestern, northeastern and southwestern portions of the state are the regional areas with the highest percentage of their populations enrolled in the Medicare program.[28] Minnesota counties with

the greatest overall percentage of poverty (comparable to the statewide figure of 8.7 percent) among their residents tend to be located in the northwestern and northcentral part of the state.[29],[30]

4. Disparities in Health Indicators

Although Minnesota ranks favorably on most health measures it has significant disparities in health status and health outcomes among various population groups:

- Rankings by private sector insurance interests consistently rate state residents as among the healthiest in the nation. Yet people of color in the state are at greater risk of heart disease, cancer, stroke, diabetes, homicides, suicides, and unintentional injuries.[31]
- The life expectancy of its residents is the second best in the nation. Yet the self-reported suicide (ever) attempt rate among its 12th grade male youth is 9 percent and among its 12th grade female youth is 15 percent.[32]
- Median household income in 1997 dollars of $41,482 (1995-7 average) is the seventh highest in the nation.[33] Yet 8.7 percent of its total population and 13.0 percent of its children under 5 live below the poverty level.[34]
- Overall infant mortality rates are consistently well below the national average. Yet the average rates for African Americans and American Indians are three times as high as other racial and ethnic groups in the state.[35]
- The percentage of low-birthweight newborns is also consistently among the lowest in the nation. Yet large disparities exist with percentage of singleton births under 2,500 grams between African American newborns and other racial and ethnic groups.[36]
- Pregnancy rates among 15-17 year-olds are decreasing. Yet the rates for Native-American teens and African-American teens remain 3 to 4.5 times higher, respectively, than the overall average.[37]

B. Health Care Delivery Environment

1. Financial Access

The state continues to maintain one of the lowest rates of uninsured populations in the nation; and unlike the rest of the country, the state's uninsured rate has remained significantly unchanged since 1990 although the profile of its uninsured has changed since then.

Estimates of the number of uninsured people in the state vary according to specific data sources, ranging from 5.2 percent to slightly more than 9 percent. Minnesota-specific studies conducted in 1990,

1995 and 1999 indicate the uninsured rate was 6.0 percent in both 1990 and 1995 and 5.2 percent in 1999.[38] National data from sources such as the Current Population Survey (CPS) estimate the uninsured rate at the higher level of 9 percent.[39] (The CPS two-year, 1997-98 estimate of uninsured Minnesotans is 9.2 percent.) Analysis of the 1999 study by the Health Economics Program of the Minnesota Department of Health reveals that children 17 and under made up a smaller proportion of the uninsured in 1999 than they did in 1990 or 1995 (16.5 vs. 25.0 and 18.2 percent, respectively) and that this pattern holds true when children's age cohorts are divided into birth through five years and six through seventeen.[40] In addition, the overall rate of uninsured children declined from 5.3 percent in 1990 to 3.4 percent in 1999. An important trend observed from the state-specific studies is a decline in the proportion of long-term uninsured who are children. In 1990 almost 29 percent of the long-term uninsured (defined as being without insurance for 12 months or longer) were children under the age of 18; by 1995 this figure had fallen to 17.4 percent and in 1999 it fell to 14.6 percent.[41] It is important to note, however, that while the percentage of children who lacked health insurance for twelve months or more decreased during this time frame, the proportion of those who were uninsured for part of a year who were children remained unchanged between 1990 and 1995 at 26 percent but then declined to 22 percent in the 1999 study.[42]

According to 1997 data compiled by the Health Economics Program of the Department of Health, two-thirds to 70 percent of the state's population had private sector health insurance and approximately 25 percent of the state's residents had insurance either through Medicare (14%) or through one of the state's three publicly funded programs (Medical Assistance or Medicaid [8%], MinnesotaCare [2%], and General Assistance Medical Care [#1%]).[43] The remainder of the population was uninsured. Self-insured (ERISA) plans cover 29 to 32 percent of all state residents or about 43 percent of those Minnesotans with private health insurance, a percentage figure that has remained stable since 1994.[44] In 1997 almost one-half of enrollees in self-insured plans were in plans administered by HMOs compared to 20 percent in 1993 and enrollment in HMOs of Minnesotans in private, fully-insured plans rose from 48 percent to 55 percent in that 1993-97 time period.[45]

2. State Funded Programs

Minnesota provided health insurance coverage for 645,000 state residents at some point during 1999 through its Medical Assistance (MA or Medicaid), General Assistance Medical Care (GAMC), and MinnesotaCare programs.[46]

Medicaid or Title XIX

Medical Assistance (MA) is the state's Medicaid program and provides acute, chronic and long-term care services to low-income seniors, children and families, and people with disabilities. Families, children and pregnant women account for 68 percent of Minnesota's MA enrollees and 22 percent of its expenditures.[47] Program expenditures for state fiscal year 1999 totaled $2.9 billion with the federal/state contribution ratio set at 51.5/48.5.[48] Enrollment as of December, 1999 was estimated at 361,633 including 200,092 children under 21.[49] Comparable figures for December, 1998 were 365,000 including 202,000 children under 21; and for December, 1997 were 381,000 and 214,000 respectively (Minnesota Department of Human Services, G. Hoffman e-mail communication, April 4, 2000).

The state currently operates its Medicaid program with five Section 1915(c) home and community-based waivers, one Section 1915(b) freedom of choice waiver, and three Section 1115 waivers. The three Section 1115 waivers include a waiver to permit implementation of performance based contracting for ICF/MR services, the Minnesota Senior Health Options waiver or MSHO, and the state's waiver for its Prepaid Medical Assistance Program (PMAP) as it was originally called or the MinnesotaCare Health Care Reform Waiver (or PMAP+) as it is now called.

The most important Medicaid 1115 waiver is the state's PMAP+ waiver. The Prepaid Medical Assistance Program (PMAP) began in 1982 when Minnesota was selected by the federal Health Care Financing Administration (HCFA) as one of five original states to implement managed care for non long-term care services for designated Medicaid populations on a prepaid, capitated basis. Medicaid populations initially covered by the PMAP program included families with children, elderly, and persons with chronic illness or physical disabilities (including blindness). The state disenrolled the blind and disabled populations in late 1987 because of policy and operational issues.

Changes that occurred over time included expansion of the program statewide, simplification of some MA eligibility requirements, federal financial participation for coverage of pregnant women and children in the MinnesotaCare program (described later in this section), and expansion of PMAP covered populations to include a) children eligible for MA under TEFRA to coincide with enrollment of persons with disabilities into managed care, b) children in foster care placement, c) children eligible for MA through subsidized adoptions, and d) on a voluntary basis, children who are seriously emotionally disturbed and who are eligible for MA-covered targeted case management.[50] As of December 1999, 58 of Minnesota's 87 counties were participating in the PMAP+ program and the remaining counties were awaiting federal (1115) approval for a form of managed care called county-based purchasing.

A 1997 state law authorized all counties to choose the type of Medicaid managed care model to be implemented in their county: either PMAP or County-Based Purchasing[51]. County-based purchasing would allow counties (instead of the state) to purchase and/or provide comprehensive Medicaid services on a risk basis contingent upon federal 1115 approval. A hybrid of the PMAP+ and county-based models is called "Enhanced PMAP" in which the state still purchases health care services, but the county becomes more of a partner in selecting contractors, RFP requirements and in provider negotiations. In 1999 the number of counties electing to participate in the PMAP+ program rose to 55 and the numbers choosing enhanced PMAP was three. Thirty-one counties (including two presently in PMAP+) have indicated their preference to opt for the county-based purchasing model, but HCFA has not issued the 1115 waiver to permit this model to proceed.[52] As of February, 2000, the twenty-nine counties that elected county-based purchasing but are not currently on PMAP+, remain on fee-for-service Medicaid.

MinnesotaCare

Minnesota began its health care reform activities in 1988 with authorization of the Children's Health Plan (CHP).[53] CHP was a state subsidized insurance plan that provided coverage only for outpatient health services to low-income children over the age of one and under the age of 9 who were ineligible for Medical Assistance or GAMC and whose family income did not exceed 185 percent of the applicable poverty guideline. The upper age limit was subsequently extended to 17. In 1992 the state began to intensify reform activities when it passed its first major health care reform legislation now known as MinnesotaCare.

Building upon the principles of the CHP, the 1992 legislation authorized, among many other reforms, a subsidized health insurance program for adults as well as children (now defined as under the age of 21, including the unborn child of a pregnant woman) and also expanded coverage to include inpatient hospital services.[54] MinnesotaCare is a state subsidized program funded by state taxes, enrollee premiums determined on a sliding-fee schedule and enrollee co-payments. It was initiated in October of 1992 and as of December, 1999 had an enrollment of 112,088 of whom 57,075 were children.[55] Families with children are eligible for the program on a sliding-fee scale if their family income is less than 275 percent of the applicable family Federal Poverty Guidelines (FPG). Currently, single adults and adult families without children are eligible on a sliding-fee basis at up to 175 percent of FPG. Other eligibility criteria also apply. The entire program was converted to managed care in the latter half of 1996. Federal financial participation is claimed for pregnant women and for children using the income standard of 275

percent of poverty with no asset standard. Covered benefits for these two populations are the same as those provided for under the Medical Assistance (Medicaid) program.

Erosion or crowd-out barriers consist of essentially three eligibility provisions. First, children, families and pregnant women must be permanent residents; families without children must not only be permanent residents, but also must have resided in the state for six months prior to enrollment. Second, individuals cannot have had other health coverage for four months prior to enrollment except for children in families with income at or less than 150 percent of FPG or for individuals making a transition to MinnesotaCare from MA or GAMC. The third eligibility provision denies, with certain exceptions, eligibility for individuals who have had access to employer subsidized insurance (50 percent or more of premium cost) in the 18 month period prior to enrollment in the MinnesotaCare program.

General Assistance Medical Care (GAMC)

GAMC is a state and locally funded program that covers acute care services for residents not categorically eligible for MA but who meet income and asset standards comparable to the medically needy standards of the MA program. Individuals who may be eligible include non-citizen children, persons who are incapacitated or of advanced age, undocumented and nonimmigrant persons. Program enrollment as of December, 1999 was 22,419 including 596 children. The program provides coverage for the same health services offered by the MA program except for long-term care, home care or personal care services.

Childrens's Health Insurance Program (CHIP) or Title XXI

In September of 1997 the Minnesota Department of Human Services convened a statewide stakeholders group to begin discussion of a Title XXI plan. This discussion ultimately resulted in legislation signed by the governor on April 9, 1998.[56] This law directed the Department of Human Services to request Title XXI funding for the following three areas:

- Expansion of the Medical Assistance income standard for children under age two from 275 percent to 280 percent of Federal Poverty Guidelines;
- Expenditures for children enrolled in MinnesotaCare, and other services and administrative activities that may be eligible for enhanced funding which would require Title XXI waivers from
    - The 10 percent cap on expenditures for special health initiatives, direct payments to providers and administrative costs.
    - The definition of "targeted low-income children" so that enhanced matching funds would

become available for children with family income above mandatory MA income standards.

- Premium and cost-sharing requirements so that the MinnesotaCare program would continue its stability.
- Certain maintenance of efforts requirements. and;

- A proposal to subsidize employer-based insurance for children of employees who are ineligible for MinnesotaCare due to the availability of employer-subsidized insurance.

The expansion of the income standard for children under the age of two to 280 percent of poverty guidelines was approved by the U.S. Department of Health and Human Services as a Medicaid expansion under Title XXI in July of 1998. The state's request for waivers from Title XXI requirements to enhance matching funds for children enrolled in MinnesotaCare and for other health initiatives was denied at that time because HCFA decided that waivers of Title XXI were premature in the first year of the program. The proposal to subsidize employer-based insurance was reviewed by the Legislative Commission on Health Care Access, a ten-member legislative oversight commission comprised of state senators and representatives, in December of 1998 and rejected. Bills were introduced in both the House and the Senate in the 1999 legislative session proposing the subsidy, but none were passed. In March of 2000, the state submitted a second waiver request to HCFA focused on expanded enrollment of its MinnesotaCare program, presumptive eligibility for that program and cost-sharing compatibility with Title XXI limits. To date, there has not been any formal response from HCFA.

3. Private Sector Trends/Managed Care

The vast majority of health care delivered in Minnesota occurs within the private sector. Several trends in health care delivery and financing are important in understanding the relationships between the private and public sector. First is the substantial amount of managed care growth that has occurred in the last few years combined with the interplay commercial managed care and Medicaid managed care have on one another and on a health plan's overall financial performance. About 60 percent of Minnesotans were enrolled in some type of managed care plan in 1990 and by 1995 this had increased to 80 percent. Between 1993 and 1997, the enrollment rate in HMOs of employed Minnesotans increased from 25 to 31 percent, enrollment in preferred provider organization/point of service arrangements increased from 38 to 59 percent and enrollment in indemnity plans decreased from 37 to 10 percent.[57]

It is the state's goal is to continue to reduce the number of its residents who do not have health coverage.[58] A complementary statewide goal is to expand delivery of services to Medicaid recipients

through managed care. As noted above in the discussion on the state's Medicaid program, 58 of Minnesota's 87 counties are already participating in PMAP+ with the remaining counties (including 2 of the 58) waiting for federal 1115 approval to implement county-based purchasing. Also as noted above in the discussion on MinnesotaCare, that program was converted in its entirety to managed care by the end of 1996.

This predominance of managed care now has many forces further shaping and refining it. A sizable portion of the state's managed care market share is controlled by licensed HMOs. The state estimates that HMOs enroll about 50 percent of the state's population that is covered either through contracts with self-insured employers or through contracts for fully-insured (commercial) plans.[59] This would translate to approximately one-third of the entire population and does not include populations served by other managed care types of delivery such as PPOs. The revenue streams of licensed HMOs have been under substantial stress in the last four years because of intense premium and market share competition in the commercial HMO area. (The state does not collect data from HMOs in their roles as third party administrators or as a delivery system for an ERISA plan, nor does it collect data on PPOs.) Consequently, premiums have increased accordingly. While no systematic data exists across all populations, data on state employee group health premium costs indicate a 6.7 percent increase in 1997and a 10.1 percent increase in 1998. Commercial premiums rose by 8.1 percent in 1998 for the state's HMOs. Increases in 1999 for the small group market range from 9 to 28 percent for the HMOs.[60]

Although most plans have experienced a loss on their fully-insured and Medicare-risk products in the last few years, they have had a net profit because of earnings from investments and profits earned on Medicaid managed care plans (PMAP+). However, pending changes (e.g. county-based purchasing and direct contracting) may have significant impact on the level of profits of managed care plans in the Medicaid and Medicare areas which would lead to greater pressure to increase premiums for fully-insured populations.

In addition, the impact of the provisions that both the Balanced Budget Act of 1997 and the BBA Refinement Act of 1999 (P.L. 106-113) will have on Medicare managed care and the concept of direct contracting for Medicare enrollees is not completely understood in the state. The impact of many of the changes due to the BBA of 1997 in Medicare, Medicaid and S-CHIP, and now the 1999 BBA, and the interrelationships among one another of those changes are only beginning to have their presence felt in the state's marketplace.

There is a private sector direct contracting initiative being undertaken in the Minneapolis/St. Paul

metropolitan area by the Buyers Health Care Action Group (BHCAG). This group is a coalition of 26 self-insured employers that helped to support a number of reforms in the early 1990's, including the concept of vertical integration between insurers and providers. By 1995-96, however, it had become concerned about the magnitude of the consolidation of health plans, insurers, hospital and physician systems that had occurred in the state and, in particular, the Twin Cities. As a result, BHCAG signaled its intent to contract directly with small groups of providers on behalf of its members' employees and their dependents in a manner that it believes will not jeopardize the employers' self-insurance status.

C. Title V Program Role

The role of the Title V program in the state's health care delivery environment is to assess the health needs of mothers, children, and their families and to use that information to effectively advocate on their behalf in the development of policies concerning organizational and operational issues of health systems, and to advocate for programs and funding streams which have the potential to improve their health. The state's Title V program does have a significant assurance role. However, as explained in the previous section the need for it to engage in safety-net medical services delivery is very limited.

The Division of Family Health in the Minnesota Department of Health (MDH) administers, coordinates and supports many activities addressing maternal and child health, including the Title V Block Grant. The maternal and child health responsibilities of the Division include statewide planning and coordination of services through the acquisition and analysis of population-based data, the provision of technical support and training; coordination of various public and private efforts; and support for targeted preventive health services in communities with significant populations of high risk and low income families.

Program goals described in a later section are accomplished through partnerships with both state and local level agencies. The Department has interagency agreements with the Department of Human Services related to Title V/Title XIX activities, and also partners with local Community Health Boards, the Departments of Children, Families and Learning; Economic Security; Corrections; and Public Safety. (See Appendix C. State of Minnesota Quad-Agency Interagency Agreement related to coordinated service for Minnesotans who are deaf, blind, and hard of hearing.)

D. Current Departmental Priorities/Initiatives - Title V Program Involvement

As the Minnesota Department of Health positions itself for the next four to ten years, its priorities will be shaped by legislative and gubernatorial direction as well as community- and population-based health

issues. The current governor, Jesse Ventura, has directed that a four part initiative be undertaken throughout all levels of state government called "The Big Plan". Its four components include building healthy, vital communities; self-sufficiency of state residents; state government dedicated to service; and a state that is competitive in the world's marketplace. Within the many sub-initiatives of these four components is one on health system reform focused on producing better health status for all Minnesotans.

In 1999 the Department adopted a set of strategic directions on issues it felt to be crucial to ensure a vital and healthy Minnesota.[61] These issues include elimination of disparities in health status, improvement of the readiness of the department's response to emerging health threats, reduction of tobacco use and improvement of the health of Minnesota's youth, bringing the community together on state public health goals and preparing the state for the next wave of health care reform.

Throughout 1998 the Department undertook an effort to revise the state's public health goals and objectives.[62] Title V program staff were actively involved and a significant number of the goals relate to maternal and child health and are thus being addressed by Title V program activities. (See Appendix D., *Healthy Minnesotans Public Health Improvement Goals 2004*).

Following development of the public health goals and objectives, the Department published *Strategies for Public Health*, which is a compendium of ideas, experience and research offered to help local public health and other community agencies achieve the objectives of *Health Minnesotans, 2004.*[63] Title V staff were actively involved in the development of the strategies document.

An analysis conducted in late 1999 documented the significant extent to which Title V is involved in activities related to the Department's strategic directions and public health goals. In particular, the state Title V program is significantly affected by the disparities issue. Minnesota consistently scores high on rankings of state's measures of health status. However, as noted previously this status is not equally shared among its racial and ethnic populations and very large disparities exist in indicators of infant mortality and teen pregnancy. In 1999 Title V program staff, in partnership with the Department's Office of Minority Health, developed an application to the Centers for Disease Control and Prevention (CDC) for a *REACH* (Racial and Ethnic Approaches to Community Health) demonstration grant. The grant was awarded by CDC to establish a community-based planning process to develop a comprehensive action plan for systems change related to reduction of infant mortality in the African-American and American-Indian communities residing in Hennepin (Minneapolis) and Ramsey (St. Paul) counties. In addition, the Title V program co-sponsored a symposium in mid-1999 to address the adolescent pregnancy rate among African-American adolescents, which is among the nation's highest and has subsequently supported follow-up

activities by the Office of Minority Health.

Although the Title V program has many partnerships it continues to give particular attention to its relationship with local Community Health Boards and is involved in a number of collaborative activities to strengthen and enhance communications. In the area of disparities, the state Title V program was actively involved in planning for the Healthy Start grant awarded by the federal Maternal & Child Health Bureau to the Minneapolis Department of Health and Community Services to address the same goal as the REACH grant.

E. Decision-Making Process In Face Of Competing Factors

There are a number of institutionalized forums that allow the commissioner of health, and the Family Health Division director to remain up-to-date on the social, political and economic dynamics affecting health care issues. Some of them are described more extensively under the State Agency Coordination section and in other sections of the application. All of the groups described below provide for a statewide perspective of various stakeholders on different policy issues which affords the Title V director a number of different vehicles for defining problems and policy and for feedback on recently enacted policy.

1. Health Steering Team (HST)

The HST consists of the health department's Executive Office staff and the division directors. It meets every two weeks to provide input into departmental policies, determine priorities, and to identify and resolve issues.

2. State Community Health Services Advisory Committee (SCHSAC)

The SCHSAC is a standing advisory committee comprised of county commissioners and local community health administrators. It meets at least four times a year and its purpose is to advise the commissioner of health on all matters relating to the development, maintenance, funding and evaluation of the local public health system. In addition, each year the SCHSAC forms 3-5 work groups comprised of local public health experts to address topics of pressing interest to local public health agencies. It also sponsors an annual statewide conference for state and local public health professionals.

3. Maternal and Child Health Advisory Task Force (MCHATF)

The MCHATF is another standing advisory committee that assists the Commissioner of Health on

selected policy issues. It is a 15 member group equally represented by consumers, maternal and child health professionals, and community health agency members with ex-officio representation from the Minnesota Department of Human Services, the Minnesota Department of Children, Families and Learning and the University of Minnesota MCH Program. Its purpose is to advise the Commissioner, the Division Director and the Title V program on the health status and health care needs of mothers and children. It too, forms work groups to address issues or topics that are of particular concern. (See more detail in section 1.5.1.2 A.)

4. Rural Health Advisory Committee

This health department advisory committee consists of legislators, rural providers, and consumers. Its purpose is to advise the Commissioner and other state agencies on rural health issues and rural health planning. It too carries out its responsibilities through work groups.

5. Minnesota Health Improvement Partnership (MHIP)

The MHIP is a broad coalition of statewide health care organizations including health plans, professional associations, and consumer advocacy organizations. It was formed to advise the Commissioner and Department of Health on activities that could advance the vision of health as a shared responsibility and to develop coordinated public, private and non-profit efforts to improve the health of Minnesota residents. As a part of its workplan, an Adolescent Health Services Action Team is meeting to review current state and national recommendations and reports regarding the delivery and financing of health services for adolescents, assess the extent to which the recommendations have been implemented in Minnesota and identify barriers to implementation, and make recommendations to assure a solid continuum of clinical and community based health services for this population.

6. Title V/Title XIX

The senior program managers for the Title V and the Title XIX programs meet periodically to discuss maternal and child health issues and proposed changes in their respective programs and concerns due to changes in federal and/or state policy. The Title XIX agency is also the designated Title XXI agency.

7. Division Management

The Division Managers and the Section Managers of the Division of Family Health meet on a

bi-monthly basis to resolve immediate operational issues and to discuss and define long-range issues.

1.5 THE STATE TITLE V AGENCY

1.5.1 STATE AGENCY CAPACITY

1.5.1.1 ORGANIZATIONAL STRUCTURE

A. Minnesota Department of Health

The Minnesota Department of Health (MDH) is one of the major administrative agencies of state government. Its Commissioner of Health is appointed by the governor with confirmation by the state senate. The Commissioner serves at the pleasure of the governor. Minnesota Statutes, Chapter 144 contains the state law specific to the Minnesota Department of Health including its overall authority and many detailed requirements such as those related to vital statistics, health records, consent of minors for health services, lead absorption, children's camps, hospital regulation, etc. State law imposes upon the Commissioner the broad responsibility for the development and maintenance of an organized system of programs and services for protecting, maintaining, and improving the health of the citizens of Minnesota. The Department is charged directly by state or federal law to perform four types of functions. These are: 1) to provide direct services, either to the public or to institutions which serve the public; 2) to provide consultation, training, and technical services to local health agencies and various professional groups working in public health-related fields or in occupations which can affect those working in public health-related fields or in occupations which can affect the health of the public; 3) to monitor local health agency programs which are subsidized by the state or supported with federal funds to assure effective and efficient delivery of services; and 4) to receive federal funds designated for public health and prevention purposes and distribute them to state and local programs in accordance with federal requirements and state health priorities.

The MDH is organized into an Executive Office and three Bureaus. Within the Bureau of Family and Community Health is the Division of Family Health which is responsible for "the administration of programs carried out by allotments under Title V". The Division is organized into the Director's Office and five sections all of which engage in maternal and child health activities: Maternal and Child Health (MCH), Minnesota Children with Special Health Needs (MCSHN), Center for Health Promotion, Supplemental Nutrition Programs and the Tobacco Prevention and Control Section. Appendix E.1 contains organizational chart of the Minnesota Department of Health and E.2 the Division of Family Health. See Appendix F. Maternal and Child Health Act - Minnesota Statutes.

Other specific statutes related to the Title V programs include: Family Planning M.S. 145.925, Genetics M.S. 144.91 & 2, M.S. 144.125, 6&8, and Infant Mortality M.S. 145.90.

B. Community Health Boards

The delivery of primary and preventive health care services by local government in Minnesota occurs within a framework governed by "Community Health Boards. The Boards themselves are comprised of elected officials, either county commissioners or city council members, although the

Boards have the authority to appoint non-elected officials to the Board. The Boards provide policy formulation and oversite of the local public health administrative agencies which are responsible for conduct of public health core functions and delivery of community public health services directly or through contracts. Program services include disease prevention and control, emergency medical services, environmental health, health promotion, home health and family health. There are 50 Community Health Boards in the state including 22 single-county boards, 66 counties cooperating in 23 multi-county boards, four cities, and one city-county board.

Boards must comply with a number of statutory requirements including a comprehensive assessment of the health status of the population for which the Board is responsible. This is done on a four year cycle with the resulting community health plan updated two years later. Budgets are prepared annually. This infrastructure provides for a community-based decision-making process based on a needs assessment with state leadership and support. The process recognizes differences among communities and provides a flexible range of responses. Core funding is provided by an ongoing state subsidy. However local funding is the major funding source. (19 million state subsidy, $70 million local tax levy. Balance is grants, 3rd party payments, fees, etc. totaling approximately $250 million annually.)

In keeping with the requirements of state law, two-thirds of the MCH block grant is allocated to the state's 50 Community Health Boards through a formula.

C. Maternal and Child Health Special Project Grants Program

The Maternal and Child Health Special Projects (MCHSP) grant program was created in 1985 to distribute two-thirds of Minnesota's share of the federal MCH Title V Block Grant and an appropriation of state general funding to Minnesota's Community Health Boards.[64] MCHSP funds provide core funding for support of local public health infrastructure focused on the improved health of mothers, children, and their families. The program also targets funds to serve high-risk and low-income individuals in four statewide

priority service areas: improved pregnancy outcomes, family planning, children with handicapping conditions/chronic illness, and childhood injury prevention. Additionally, certain child and adolescent health services are authorized for the cities of Minneapolis and St. Paul and the counties of Goodhue and Wabasha.

Over the last few years, several changes in maternal and child demographic data and risk factors have occurred and the MCHSP funding formula was determined to be in need of revision. Accordingly, in 1998 a work group of the Maternal and Child Health Advisory Task Force was formed to develop recommendations for updating the funding formula. The result included recommendations for a new formula, a new funding floor, and policy changes including authorization to provide child and adolescent health services statewide. This recommendation was accepted by the Commissioner of Health and introduced into the 1999 legislative session but was not enacted into law.

1.5.1.2 PROGRAM CAPACITY

A description of program capacity within the Division of Family Health follows:

A. Director's Office

The Division of Family Health has a broad and diverse focus of responsibilities and activities which it undertakes in order to improve the health of Minnesota's individuals, families and communities. The Director's Office is responsible for overall management, administration, and direction of the Division. Included in this are activities of program planning, development, evaluation, and coordination. The Division of Family Health Mission Statement is as follows:

The Division of Family Health is responsible for ensuring optimal health outcomes for children, families, and communities. Its mission is to use science-based approaches to promote the health of all Minnesotans through out the life cycle by providing leadership in systems development and the performance of the core functions of public health: assessment, policy development and planning, and assurance. Activities within the division are accomplished through collaborative partnerships with community health boards and other local, regional, state and national entities.

The Division Director is an occupational therapist by initial training. She completed a Master of Science in Public Health degree in 1997 and has had many years of experience in maternal and child health program administration and planning; policy development and analysis; and interagency collaboration. Appendix G. contains her biographical sketch. Director's Office staff by funding source include:

1 FTE Division Director (State) 2 FTE Assistant Division Directors (State) 1 FTE Research Scientist (Title V) 1 FTE MCH Planner (State) 1 FTE Project Consultant, Sr. (State) 2 FTE Project Functional Managers (State)	2 FTE LAN Management Specialists (State) 1 FTE Oral Health Consultant (State) 3 FTE Support staff (State - CDC) 1 FTE Coordinated School Health Director (CDC) 1 FTE Coordinated School Health Consultant (CDC)

1. Data Capacity Building

A Research Scientist position was created in the Director's Office 1996 to provide expertise to the maternal and child health programs to build epidemiologic and analytic capacity within the Division; assist with the development, implementation, and ongoing assessment of a state-wide, population-based needs assessment system; assist with interpreting data and translating data into policy; enhance and develop Division capacity to monitor, track and evaluate population health status and programmatic interventions; and establish linkages with and between public and private agencies that collect data on the maternal and child populations. Since then capacity has been added to the MCH and MCSHN Sections of the Division resulting in a team approach to these research issues.

2. Dental Health

Dental Health is a one person program that provides oral health training, technical consultation, and educational materials to Community Health Boards, schools and the general public. This program also works with the Department of Human Services in areas of dental policy and access issues.

3. Suicide Prevention

A Project Consultant Senior position was created in the Director's Office in 1999 in response to the 1999 Minnesota Legislature's direction that the Minnesota Department of Health (MDH) conduct a study of suicide in Minnesota and, in consultation with a large group of stakeholders, develop a statewide suicide prevention plan. MDH submitted a Report to the Minnesota Legislature: Suicide Prevention Plan on January 15, 2000 and convened monthly meetings through June 30, 2000 of an ad hoc advisory group which provided recommendations to MDH on the development and implementation of the state suicide prevention plan.

4. Youth Risk Behavior

The Youth Risk Behavior Endowment is a new Minnesota Department of Health initiative that will give local public health agencies an opportunity to address a broad range of youth risk behaviors and the risk and protective factors that influence these behaviors. The targeted risk behaviors include alcohol and other drug use; sexual behaviors that may result in pregnancy, HIV and STDs; violence; suicide; physical inactivity; and unhealthy dietary behaviors. Funding for this initiative is provided through the Tobacco Prevention and Local Public Health Endowment established during the 1999 legislative session. Funding will be provided to all Community Health Service agencies through non-competitive grants. Funding for the first year (July 1, 2000 - June 30, 2001) will be $2.0 million growing to approximately $5 million in 2003.

5. MCH Advisory Task Force

The Maternal and Child Health (MCH) Advisory Task Force was created by the Minnesota Legislature in 1982 to advise the commissioner of health on the health status and health care services needs of Minnesota's mothers and children, and the distribution and use of federal and state funds for MCH services.[65] Fifteen members are appointed by the commissioner with five each representing MCH Professionals, MCH consumers, and Community Health Boards. Terms are four years, half coterminous with the governor's term and half one year later. The Task Force is staffed by a Principal Planner in the Division Director's Office, and Task Force projects are staffed by appropriate consultant staff of the division's sections. Work groups of the Task Force are often convened with a specific charge to bring back to the full Task Force recommendations made following more in-depth research and discussion. Examples of recommendations made by the full Task Force and forwarded to the commissioner in this manner include: development and subsequent revision of the MCHSP distribution formula and refocusing of state MCSHN program activities to better complement community-based activities, and guidance of needs assessment process. The full Task Force meet at least four times per year, in addition to members' participation on a variety of related committees. During the full Task Force meetings, members' input is solicited on priority MCH needs and strategies, and on integrating required Title V activities with MDH's *Strategic Directions*, developed under the current administration.

6. Coordinated School Health Project

The Centers for Disease Control and Prevention, Division of Adolescent and School Health (DASH) is funding initiatives in sixteen states that are designed (1) to build a coordinated education and health agency infrastructure to support coordinated school health programs and (2) to strengthen comprehensive school health education to prevent important health-risk behaviors and health problems. Minnesota is one of the states funded for this initiative and received its initial grant in late 1995. The grant facilitated the creation of a partnership between the Minnesota Department of Children, Families, and Learning (the fiscal agency and program coordinator) and the Minnesota Department of Health. The MDH component of the Coordinated School Health Project is a staffed in the Division Director's Office. The project was awarded a five year CDC cooperative agreement in December of 1997.

The Coordinated School Health Program (CSHP) is defined as a planned and comprehensive school-based program designed to enhance child and adolescent health. It is made up of eight components including healthful school environment; health services; health education; physical education; counseling, psychological and social services; nutrition services; parent/community involvement; and health promotion for staff. The primary premise is a model that involves all aspects in a planned and comprehensive CSHP that will (1) eliminate program gaps and overlap, (2) provide more effective programming, and (3) improve the school's ability to enhance the health of children and adolescents.

For CSHP to exist and perform consistently over time, it must be fully institutionalized within state and local education and health agencies and supported by an infrastructure. This includes a coordination of programs within and among the state education, health and other agencies so that CSHP receives consistent and continuous support within the overall public/community program. Title V staff have been integral to the development of the project.

B. Maternal and Child Health

The Maternal and Child Health Section of the Division of Family Health is organized into the Section Manager's office and four units: Reproductive Health, Child and Adolescent Health Screening/Health Promotion, Child and Adolescent Health Policy and Support. All but two persons are based in the St. Paul Central Office. The Section Manager is a board eligible public health physician with over 25 years experience in maternal and child health administration. Other staff within the office include the staff responsible for fiscal management of the Section and data activities including the Title V needs assessment and performance measures development and reporting.

MCH Section staff, by funding source and unit are as follows:

Section Manager's Office 1 FTE Section Manager (State) 1 FTE Management Analyst (Title V & State) 1 FTE Research Scientist (SSDI) *Reproductive Health Unit* 1 FTE Infant Mortality Specialist (State) 3 FTE Disparities Project Specialists (CDC) 1 FTE Perinatal Nursing Specialist (Title V) 1 FTE Family Planning / Reproductive Health Specialist (Title V, Section 510 and State) 1 FTE Family Planning Specialist (State) 3 FTE Abstinence Education Specialists (Section 510 and State) 1 FTE Geneticist (Title V) *Support Unit* 3 FTE Support staff (2 State and 1 CDC) 1 FTE Support staff (.25 Title V, .25 Abstinence and .5 State)	*Child and Adolescent Health Screening/ Promotion Unit* 1 FTE Supervisor (Title V) 2.6 FTE Hearing and Vision Specialists (Title V and SPRANS) 1 FTE Child Health Nursing Specialist (Title XIX) 1 FTE Child Health Nursing Specialist (Title V) 3.8 FTE Home Visiting Specialists (State) *Child & Adolescent Health Systems Policy Unit* 1 FTE Policy Specialist/Supervisor (Title V) 1 FTE Child Health Specialist (state) 1 FTE Child Care and School Health Specialist (Title V) 1 FTE Adolescent Health Specialist (Title V) .5 FTE Child Mental Health (MH) Specialist (.4 state and .1 V) 1 FTE School MH Project Co-coordinator (SPRANS) 1 FTE Communications Specialist (Title V)

The Maternal and Child Health program strives to improve the health status of children and youth, women and their families. The MCH Section provides a focal point for influencing the efforts of a broad range of agencies and programs committed to this goal. The Section supports their efforts by providing administrative and program assistance to Community Health Boards, schools, voluntary organizations, community collaboratives, and private health care providers.

In addition to its technical support efforts, the program is also responsible for administering the

state-funded Family Planning Special Projects and MN ENABL (Education Now and Babies Later) grant programs, the Maternal and Child Health Special Projects grant program funded by federal Title V funds supplemented by state general funds, the Abstinence Education grants and contracts (Section 510), contracts for Maternal and Fetal Infant Studies (state), Sudden Infant Death Syndrome services (Title V), Home Visiting Program to Prevent Child Abuse and Neglect grants and contracts (state), and Minnesota Healthy Beginnings (MHB) grants and contracts (state).

The primary functions of the activity have been quality assurance of public sector health services, assurance of targeted outreach and service coordination for hard-to-reach and high-risk populations, and community health promotion. Increasingly attention is being directed to assessment of health problems and policy development and planning.

1. Reproductive Health

The Reproductive Health program unit works with health providers to develop quality preconception, family planning, prenatal, perinatal, and genetics services that increase the potential for healthy pregnancies and newborns. This unit assesses needs, develops standards, and provides technical support services, training and public education. It administers the Family Planning Special Projects, MN ENABL, and Abstinence Education grants programs. The component also assures counseling and education for patients and family members with known or suspected genetic diseases; assures genetic consultation, education and diagnostic support to physicians and other health professionals; and partners with the Public Health Laboratories program for detection of metabolic diseases through newborn screening. The unit also includes the Infant Mortality Reduction Initiative (IMRI) and Women's Health coordination. The Women's Health coordination provides opportunity for the women's health programs of the Department to work together so that systems of care serving women are improved. The IMRI administers contracts and provides support services regarding improved pregnancy outcomes. This unit is also the focus of the "Reaching to Eliminate Health Disparities in Minnesota" Project. This Project, funded by the federal Centers for Disease Control and Prevention, targets the African American and American Indian population of Hennepin and Ramsey Counties and seeks to eliminate infant mortality disparities by 2010.

2. Child and Adolescent Health Screening/Health Promotion

The Child and Adolescent Health Screening/Health Promotion program unit supports accessible

high quality health and developmental screening and health promotion for all children in the state. Goals of the program are adoption of healthy behaviors and assurance of early identification, treatment and remediation for those with health problems. Services include development of child health screening and health promotion guidelines, provision of training and technical consultation, audiometer calibrations, and public education efforts. Specific programs supported include Child and Teen Checkups (Minnesota's EPSDT program) consultation and training under contract with the Department of Human Services, the hearing and vision screening program, Denver Developmental Screening Test II trainings, Nursing Child Assessment Satellite Training (NCAST) program, and the scoliosis screening program. The voluntary universal newborn hearing screening (UNHS) program received funding from HRSA/MCHB for the period April 1, 2000 to March 30, 2004. The funding will support expansion of UNHS activities especially in the areas of early intervention and follow-up, provider training and public information. Program activities will be coordinated with Part C staff from the Departments of Health (MDH), Human Services (DHS), and Children, Families and Learning (DCFL) along with other MDH staff and the University of Minnesota Department of Otolaryngology.

The unit also includes two home visiting grant programs. The Home Visiting Program to Prevent Child Abuse and Neglect, originally established in 1992, is a public health nursing program that provides intensive, long-term home visitation services targeted to families with identified risk factors. The purpose of this program is to prevent child maltreatment and to promote positive parenting practices. Minnesota Healthy Beginnings (MHB), established in 1997, is a universally-offered program that provides less intensive home visitation to all families with newborns, irrespective of income or risk. The purpose of the MHB program is to strengthen families and to promote positive parenting and healthy infant development.

3. Child and Adolescent Health Policy

The Child and Adolescent Health Policy unit creates a focus for policy and system development and integration to assure that the health needs of children and adolescents are adequately addressed in future policy, program and service delivery arrangements. This includes assessment of child and adolescent health needs and provision of leadership to support health care reform activities and community collaboratives to develop improved arrangements for the delivery of an array of children's services. Specific attention is given to promotion of the health and safety of children in child care settings, school health and adolescent health issues. Support is provided for the Children's Integrated Mental Health Fund (administered by the Minnesota Department of Human Services) and consultation is provided to state and

local entities so that funding for services which focus on prevention and the
Staff work closely with Coordinated School Health Project staff in the Director's office and Title V policy staff in the Minnesota Children with Special Health Needs (MCSHN) Section.

The unit has provided staff and resources for the design, implementation and evaluation of the Youth Risk Behavior Endowment established by the 1999 Minnesota legislature with funds from the Minnesota Tobacco Settlement. This endowment provides funding to local public health agencies to address and reduce youth risk behaviors. The program has been designed to integrate healthy youth development activities with risk reduction strategies, emphasizing the involvement of youth and the community in all aspects of program planning and implementation.

C. Minnesota Children with Special Health Needs (MCSHN)

The purpose of MCSHN is to improve the quality of life for Minnesota children and adolescents with special health needs and their families. The MCSHN Section is structured into two units: the Research/Analysis and Policy Unit and the Community Systems and Development Unit. The Section Manager position is currently vacant. Interim direction provided by an acting Section Manager and the two unit supervisors. Staff are located within the central office (located in St. Paul) except for five field staff each assigned to one of five out-state district offices.

Professional staff equivalents by funding source are as follows:

1 FTE Section Manager (State)	*Research and Policy Unit*
Community and Systems Development Unit	1 FTE Supervisor (Title V)
1 FTE PHN Administrative Supervisor (Title V)	1 FTE Research Analyst (Title V)
5 FTE Public Health Nurse Consultants (Title V)	1 FTE Data Specialist (Title V)
4 FTE Social Work Consultants (2 State, 2 Title V)	2 FTE Policy Advisors (State)
3 FTE Health Program Aides (Title V)	1 FTE Part C Data Specialist (Part C)
2 FTE Clinic Transcribers (Title V)	1 FTE (SAFE at Home Grant)
1 FTE Account Technician (Title V)	1 FTE Principal Planner (Part C)
2 FTE Health Program Representative (Title V)	1 FTE Tracking and Follow-Along
1 FTE Speech Pathologist (State)	Coordinator (Part C)
6 FTE Clerical Support Staff (5 Title V, 1 Part C)	1 FTE Special Project Coordinator (Part C)

Staff includes five persons who have children with special health needs. Their roles within MCSHN include two policy advisors, the "Safe at Home" grant manager, an information/referral public health nurse

consultant, and a clinic transcriber.

With the emphasis on core public health functions, the MCSHN Section provides and supports a variety of services that sustain and enhance community-based systems of care. MCSHN provides reimbursement for diagnostic and treatment services; medical, developmental and rehabilitative clinic services throughout the state where comparable services are not available; technical consultation and training to public and private providers and payers, families and other state and local agency staff; family support, information and referral; participation on local, regional, and state interagency collaborative groups; and involvement in or initiation of information, research and policy issues related to the MCSHN target population.

Diagnostic services are available to any child or youth under age 21 who is a Minnesota resident and is suspected of having a chronic or disabling condition. There are no family out-of-pocket expenses for this service. Treatment services are also available to any child or youth under age 21, who has a diagnosed medically eligible condition and meets MCSHN financial guidelines. Adults with hemophilia or cystic fibrosis may also be eligible. Some families may have a cost-share associated with eligibility. See Appendix H., Minnesota Children with Special Health Needs, for the factsheet detailing evaluation and treatment eligibility criteria service information and the MCSHN cost-sharing schedule.

Clinics are a traditional component of the MCSHN program. MCSHN clinics provide quality medical and rehabilitation assessments for children with suspected or diagnosed special health needs. They serve to complement local health care and are located in communities where such services are not in existence. MCSHN clinics are staffed by a multi-disciplinary team or specialist with pediatric expertise.

MCSHN also continues to update and disseminate its condition-specific *Guidelines of Care for Children with Special Health Care Needs* which include Asthma, Cerebral Palsy, Cleft Lip and Palate, Feeding Young Children with Cleft Lip and Palate, Congenital Heart Disease, Cystic Fibrosis, Diabetes, Down Syndrome, Dear and Hard of Hearing, Hemophilia, Juvenile Rheumatoid Arthritis, Muscular Dystrophy, Neurofibromatosis, PKU, Seizure Disorder, Sickle Cell Disease, and Spina Bifida. A new guideline on Fetal Alcohol Syndrome and Fetal Alcohol Effect was developed.

1. Community Systems and Development

The Community Systems and Development Unit (Team) provides a wide variety of activities at the local, regional, and state levels with public/private agencies and families, including information and referral, child find and outreach, education and training, advocacy, technical consultation, newborn metabolic screening follow up, and program/policy development.

2. Research/Analysis and Policy

The Research/Analysis and Policy Unit (Team) was created to support and help develop the capacity to collect and analyze data for research and policy issues. It has engaged in a number of interagency collaborative activities to assess, direct and influence policy decisions which positively impact children with special health needs. Specific activities and projects for both units are described later in this document.

D. Special Supplemental Nutrition Programs

This Section of the Division of Family Health is comprised of the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and the Commodity Supplemental Food Program (CSFP). These two programs are designed to improve the health and nutritional status of the eligible populations through the provision of healthy foods, nutrition education and health care referrals. The populations eligible for these programs include: pregnant, breastfeeding, and postpartum women, infants, and children (up to the age of 5 for the WIC program and up to the age of 6 for the CSFP program). The CSFP program also serves the elderly population (age 62 and above). This Section distributes federal funds from the United States Department of Agriculture to local Community Health Boards, Community Action Programs, and Indian tribal organizations to administer the WIC program; and to local food banks to administer the CSFP program. The services provided by the Section include: program planning, program administration, breastfeeding promotion, technical consultation, staff training, professional education, program assessment and evaluation, nutrition services consultation, detection and resolution of fraud and abuse and reimbursement of WIC food instruments redeemed by authorized retail food and pharmacy vendors. About 90,000 persons per month are served. Given that the clients of WIC are often clients of MCH, there is ongoing coordination between the two sections.

E. The Center for Health Promotion

The Center for Health Promotion (CHP) works to reduce physiological and behavioral risk factors for cancer, heart disease, diabetes and other chronic diseases that result in premature morbidity and mortality, and the prevention of substance abuse and intentional and unintentional injuries. The general population is at risk for these conditions and programs have been implemented that specifically target communities, high-risk populations including mothers, children and their families, schools and health care providers. Programs units of CHP include:

1. Injury and Violence Prevention Unit

This mission of the unit is to strengthen Minnesota's communities relative to understanding and preventing injury and violence. The unit manages a Traumatic Brain and Spinal Cord Injury Registry, emergency department surveillance, and a Firearm Injury Registry. Injury prevention programs are focused on agricultural injury, home safety, sexual assault prevention, and family violence.

2. Diabetes Unit

The mission of this unit is to develop and disseminate effective science-based and culturally appropriate strategies for the prevention and control of diabetes and its complications among all Minnesotans. The unit seeks to reduce morbidity and mortality from diabetes in Minnesota by linking with and impacting health care delivery systems, community systems and the network of internal and external stakeholders that comprise the Minnesota diabetes community.

3. Nutrition and Physical Activity Unit

The mission of this unit is to shape food and physical activity choices in positive ways to promote health and reduce the burden of disease among all people living in Minnesota. Programs include: the Minnesota 5 A Day Coalition; the Minnesota Governor's Council on Physical Fitness and Sports; Fitness Fever; the 5 A Day Power Plus Program; the 5 A Day Supermarket Evaluation Project; the Fitness Fever Evaluation Project; the Nutrition Surveillance Program; the Cardiovascular Disease Prevention Program; and the Public and Professional Information Program.

4. Health Education Unit

This unit strives to promote healthy people in healthy communities by making healthy choices easy choices for all Minnesotans. Programs include: Community-based Systems Integration for Tobacco and Alcohol Prevention, FAS/FAE Prevention Program, Minnesota Healthy Communities, Chemical Health Promotion, MDH Employee Health Promotion, and the Minnesota Marrow Donor Education Program.

5. Fetal Alcohol Syndrome (FAS) Unit

The mission of the unit is to strengthen the capacity of Minnesota communities to prevent prenatal exposure to alcohol and other drugs of abuse. The goals of the unit are to determine the extent of FAS in Minnesota, to identify and promote evidence-based prevention and intervention strategies, develop and implement a multi-media public information campaign, manage community grants, educate professionals,

and develop public policy.

1.5.1.3 OTHER CAPACITY

See Program Capacity 1.5.1.2

1.5.2 STATE AGENCY COORDINATION

A. Relationship Between State and Local Public Health Agencies

See section 1.5.1.1-B & C.

B. Coordination with Office of Rural Health and Primary Care

The Office of Rural Health and Primary Care is in the Division of Community Health Services of the Minnesota Department of Health. The Title V program and the Office of Rural Health and Primary Care support one another's mission as well as the goal of the Cooperative Agreement (CA) grant is to improve access to primary care services for underserved Minnesotans. The Title V program works, in part, to further efforts of organizations that deliver health services to mothers and children and to provide leadership for statewide maternal and child health issues. Both parties recognize the need for systems development to improve the health care of their respective constituencies and agree to support one another to achieve that goal.

C. Coordination with the Tobacco Prevention and Control Program

The Tobacco Prevention and Control Section (TP&C) is in the Division of Community Health Services of the Minnesota Department of Health and coordinates and links a variety of state and federally funded activities targeting youth tobacco use prevention. A major focus this past year has been the Minnesota Youth Prevention Initiative. In 1999, the Minnesota Legislature set aside $492 million in tobacco settlement money from the state's tobacco lawsuit with a goal of reducing tobacco use among Minnesota young people by 30 percent by the year 2005. Using the interest earned from the endowment, efforts are focused on public awareness and education, and community and school-based programs. The Title V program has supported these efforts at both the state and local level.

D. Coordination with Other State Agencies

1. Department of Human Services (DHS)

The Title V program and the Department of Human Services (the state's designated Title XIX and Title XXI agency) have a long history of collaboration framed by a formal interagency agreement. See Appendix I., State of Minnesota Interagency Memorandum of Understanding. Current collaborative efforts include joint participation in the Children's Cabinet as well as the Family Service Collaboratives and the Children's Mental Health Collaboratives. DHS is represented on the MCH Advisory Task Force in an Ex-Officio status and Title V participates on the Medicaid Advisory Task Force. Title V staff participate in planning for the Children's Health Insurance Plan, Medicaid Pilot Projects for Persons with Disabilities, TANF-PHN Home Visiting Program as well as EPSDT to name a few. The collaborative activities listed above are described in more detail in other sections of the annual report and application. Formal contracts exist which provide DHS funding for staff in the Title V program relative to EPSDT (Appendix J.), children's mental health, and services to deaf, hard of hearing, and deaf-blind individuals. Management staff of MDH and DHS meet on a quarterly basis to discuss issues of mutual interest.

2. Department of Children, Families and Learning

The Title V program and the Department of Children, Families, and Learning (DCFL) also collaborate on many projects. Staff of both agencies are actively involved in the Family Service and Children's Mental Health Collaboratives. Title V staff and DCFL staff collaborate on numerous programs and projects including: Family Service and Children's Mental Health Collaboratives, Part C (formerly Part H), Coordinated School Health, Early Childhood Screening, pregnancy prevention and abstinence education programs, Fitness Fever, Minnesota Healthy Beginnings, service coordination (for ages 3-21), third party billing, a children's advocate group, and a grant advisory board regarding children with special health care needs and child care. The above projects and programs are described in more detail in other parts of the annual report and application. Interdepartmental planning around alcohol and other drugs usage by youth is also occurring. DCFL is the fiscal host for the Interagency STATES Incentive Grant.

3. Department of Corrections

The Department of Corrections participates with MDH, DHS, and DCFL on children's mental health issues in the state. This relationship has been long standing and children's mental health issues provide avenues and linkages to address children's mental health issues in juvenile correction centers. Title V staff also collaborate with the Minnesota Department of Corrections on adolescent health issues through the

Interagency Adolescent Female Subcommittee (IAFS). This group is a subcommittee of the Department of Correction's Advisory Task Force for Female Offenders in Corrections. The MCH Adolescent Health Coordinator is a member of the IAFS and provides the adolescent health perspective to its work, assuring gender-specific programming for girls in corrections.

4. Department of Public Safety

The MDH Injury and Violence Prevention Unit continues to address the public health problem of childhood motor vehicle injury by emphasizing correct installation of child safety seats. The unit has co-sponsored installation training sessions across Minnesota, teaching local hospital staff and public health professionals current installation techniques and procedures. A recent observational study in Minnesota found that nearly 80 percent of children in child safety seats were restrained incorrectly.

Collaboration with the Minnesota Center for Crime Victims Services is focused on support of community-based programs providing assistance to sexual assault victims. Preventive Health and Health Services Block Grant funds from the MDH are used, in part, to support programs at the Department of Corrections and its grantees for the prevention of sexual assault. These block grant funds also have supported Family Health Division activities to develop a sexual violence prevention resource kit for use by local public health agencies and others interested in violence prevention.

5. Children's Cabinet

In addition to its health systems reform initiatives and consistent with national trends, Minnesota is engaging in many community-based service redesign projects to better serve the needs of children and remove barriers caused by traditional categorical program approaches. A governor’s initiative and the legislature created through statute a children's cabinet to develop an integrated budget and work plan to reform and restructure the service delivery system for children and their families.[66] The mission of the children's cabinet is to improve the well-being of children and families in Minnesota.

Although inactive in the first year of the Ventura administration, the Cabinet is now meeting every two months. Eleven state agency commissioners participate in the cabinet including health; administration; economic security; public safety; finance; transportation; children, families and learning; corrections; human services; the housing finance agency; and Minnesota Planning which is the state’s office of strategic and long-range planning. Staff support for the Children’s Cabinet is provided by the Department of

Children, Families, and Learning (DCFL). The Cabinet is currently co-chaired by the Commissioners of Human Services and DCFL.

6. Children's Mental Health Collaboratives

The primary focus for children's mental health in Minnesota is the development of a community-based, unified system of services for the child and family. The Comprehensive Children's Mental Health (CCMH) Act requires that counties provide a specified array of mental health services to children.[67] The CCMH Act establishes guidelines for development of Children's Mental Health Collaboratives including integration of funds in order to use existing resources more efficiently, minimize cost shifting and provide incentives for early identification and intervention. This focus on early identification and intervention gives increased importance to public health agency efforts and expands opportunities for coordination with other services. Local partnerships with social services, corrections, and education agencies create integrated systems that improve services to children with mental health problems and provide services for their families.

7. Family Service Collaboratives

Family services collaboratives were initiated in 1993 by the Minnesota legislature which mandated public health's involvement, recognizing the vital role public health plays in assessing and addressing the health of all mothers and children in communities and the state.[68] Included in this initiative were collaboration grants to foster cooperation and help communities come together to improve results for Minnesota's children and families. By providing incentives for better coordination of services, Minnesota hoped to increase the number and percentage of babies and children who are healthy, children who come to school ready to learn, families able to provide a healthy and stable environment for their children and children who excel in basic academic skills. Recognizing that no single funding source alone is responsible for changing outcomes, a set of statewide core outcomes was distilled from the collaboratives' efforts. Promoted across systems in 1998, this list has been included in the work of the STATES Initiative, the KIDS Data Project, and Minnesota Healthy Beginnings, among others. Many of these outcomes and their indicators align with the federal/state MCH performance measures; and many others offer future directions for development of measurement tools, in particular, those with the promotional perspectives of family support.

8. II. Part C of IDEA (Individuals with Disabilities Education Act) -Early Childhood Intervention

Minnesota's Early Childhood Intervention Program (Part C) is a joint initiative of three state agencies: Health; Human Services; and Children, Families, and Learning (CFL) and local IEICs (interagency early intervention committees). The Department of CFL is the lead agency in Minnesota. Through an interagency agreement, the Department of Health receives funding for specific activities and staff, within the Minnesota Children with Special Health Needs (MCSHN) Section. The Part C health team works closely with other MCSHN and MCH staff. A MCSHN supervisor provides time to the Part C project on the mandated State Agency Committee (SAC) and the Governor appointed Interagency Coordinating Council (ICC).

The Department of Health's Part C team provides outreach, information, training, and technical assistance on health related early childhood topics and issues to families; state, regional, and local health, education, and human service agencies; public and private providers and IEICs (Interagency Early Intervention Committees). The team has primary lead for public awareness/child find; ongoing technical support of the Follow Along Program (tracking system for identifying children at-risk); a statewide information and referral line (central directory requirement); establishing and maintaining an interagency data system; coordinating a special research project (Enhanced Follow Up) to conduct enhanced follow up of children 0-3 "at-risk" for developmental delay for the purpose of estimating numbers of children at-risk, service needs and costs and facilitate families access to resources; providing training and technical assistance on managed care issues, health benefits coordination, and outreach to health care providers on Minnesota's early childhood intervention system.

9. University of Minnesota

Collaboration between the Title V agency and the University of Minnesota School of Public Health continues on various research, evaluation and training projects. The MCH program of the School of Public Health participates in the Department's Maternal and Child Health Advisory Task Force and the Department's Title V program is collaborating with the school's MCH program community education activities. A number of Title V program staff are graduates of the program. In addition, a number of MPH students have completed internships in the Division of Family Health over the past several years.

10. Coordinated System for Children with Disabilities Aged Three to 21

As a result of legislation in 1998, the state has in place a law mandating a coordinated interagency

system for children from three to 21 with disabilities, as defined by IDEA, modeled after Part C. The law requires a phase in of the system, by age groups over five years with the last group of children aged 14-21 phased in by July 2003. Staff from MDH have been actively involved with an 18 member State Interagency Committee made up of seven state agencies and others, as well as the many workgroups engaged in identifying barriers and funding sources, establishing policies and direction, designing an evaluation methodology, and developing products for use by local county boards and school boards including sample governance agreements and a standardized written plan. These activities will continue and staff will continue to participate to assure that the system meets the needs of children with special health needs.

II. REQUIREMENTS FOR THE ANNUAL REPORT

2.1 ANNUAL EXPENDITURES

Please see Forms 3- 5

2.2 ANNUAL NUMBER OF INDIVIDUALS SERVED

Please see Forms 6 -9

2.3 STATE SUMMARY PROFILE

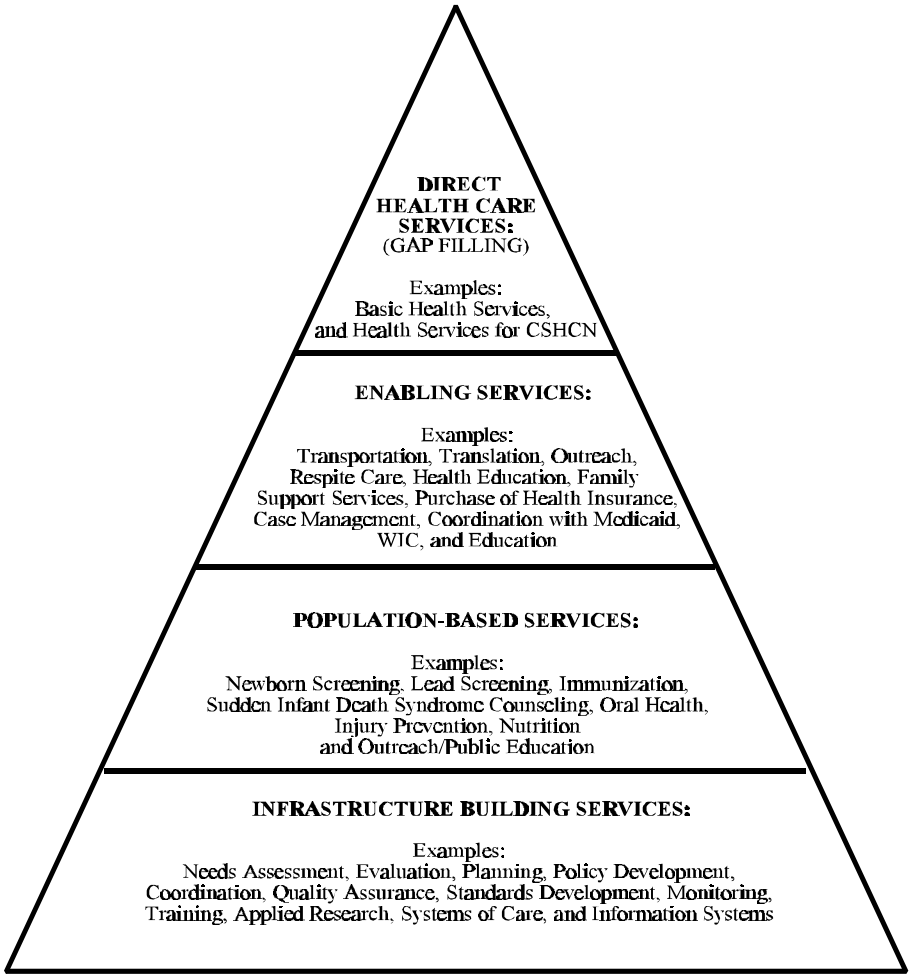
Please see Form 10

2.4 PROGRESS ON ANNUAL PERFORMANCE MEASURES

Please see Form 11 and the narrative which follows Figure a., the model of Title V services delivery which is also the framework upon which this document is organized.

Figure a

CORE PUBLIC HEALTH SERVICES DELIVERED BY MCH AGENCIES



MCHB/OSCH 10/20/97

DIRECT HEALTH CARE SERVICES

As described in part I of this document, Minnesota has endeavored to maximize non Title V resources to support direct health care services. The use of Title V funds for this purpose is thus very limited; however in its assurance role some funding is available. It is state agency policy that direct public health services be delivered locally to the extent possible. Accordingly the state MCSHN program delivers some direct services but the MCH delivery of direct public health services occurs entirely at the local level with the state MCH program engaged in administrative activities supporting direct health care delivery systems. A description of Title V direct health care activities follows.

A. Pregnant Women and Infants

SP #5 - Percent of pregnancies that are unintended.

Intended pregnancy was estimated at 57 percent among women 18-44 who were currently pregnant and at 58 percent among women 18-44 who had been pregnant in the last five years. Data was collected in 1999 from the state's Behavioral Risk Factor Surveillance System (BRFSS) on intended pregnancy.

Both Title V and state funds are expended for family planning method services. In 1999, 13 CHBs used Title V funding to provide family planning method services to 7,920 people. State dollars support the Family Planning Special Projects (FPSP) grant program. These funds are available to Community Health Boards and non-profit corporations to provide pre-pregnancy family planning services. Sixty-two (62) applications from agencies and one Statewide Hotline were funded for the calendar years 1998-99 grant cycle. A total of $10,263,405 was awarded. In 1999 the FPSP grant program served about 33,197 women for family planning method services.

An evaluation of the subsidized family planning system and of the FPSP grant program was conducted in 1998. In 1999 and continuing into 2000, a Family Planning Workgroup was convened to advise the Minnesota Department of Health on the program improvements for the FPSP grant program and on issues related to the overall family planning system based on recommendations in the System-wide Analysis of Family Planning in Minnesota Report.

B. Children and Adolescents

SP #2 - The percentage of children and adolescents enrolled in health plans who receive comprehensive preventive health visits according to nationally accepted standards.

Minnesota collected data from HMOs for the first time in 1999 on child well-care visits and

adolescent well-care visits. Data was collected for infants from birth to 15 months of age, children 3 through 6 and adolescents 12-21. The data was also collected by type of plan: commercial, medicaid managed care and MinnesotaCare. In general, the data indicate many lost opportunities for the provision of preventive care to these population groups regardless of the type of plan. See Notes for ERP Forms 1 through 16, SP #2 for additional information concerning data issues.

In Minnesota the Title XIX EPSDT program is called C&TC (Child and Teen Check-ups). Under contract with the state Title XIX agency, the Department of Human Services (DHS), Title V staff train public health nurses and private providers and approve/monitor public health clinics relative to C&TC services. C&TC services are provided by both private and public health service vendors. Private sector providers include physicians, nurse practitioners and physician assistants who perform all aspects of the program. Public health providers are primarily public health nurses who provide comprehensive screening and anticipatory guidance and refer for diagnosis and treatment. In several counties Prepaid Medical Assistance Program (PMAP) health plan administrators purchase C&TC services from county public health clinics, based upon the quality assurance activities of the Title V program.

In CY 1999, an extensive schedule of C&TC training sessions was offered including six Denver II Developmental Screening trainings, 16 hearing and vision screening trainings, and 27 in-service trainings on current health issues and the C&TC program. Participants included public health nurses, private providers, and C&TC Outreach Coordinators. Six, three-day C&TC core training sessions which focused on the components, standards, screening procedures and anticipatory guidance were held for public and private providers. On-site follow-up consultations and clinic flow assessments were provided by a MDH certified pediatric nurse practitioner for newly trained nurses.

Other MDH/DHS contract obligations included consultation on planning, development and evaluation of C&TC components and standards. In CY 1999 Title V and other MDH staff assisted the DHS in revising the C&TC periodicity schedule, especially related to lead and tuberculosis screening. Title V staff also provide technical assistance to all C&TC public and private providers as well as county C&TC Outreach Coordinators on their activities to inform new providers about C&TC services.

Preventive health care health services, based on the “Guidelines for Adolescent Preventive Services model, were provided children and adolescents in community and school-based clinics in Minneapolis and St. Paul. These services reach a population of urban youth who are at high risk for health problems, have inadequate financial access and are underserved in the traditional health care system. Title V funds supported the health services provided to 19,367 children and youth in CY 1999.

The Minnesota Department of Health provided leadership and technical assistance to the

Adolescent Health Care Coalition, a collaborative of health care providers, health plans, health associations, government, public health, hospitals, foundations and non-profit agencies working to change the health care system to better meet the health needs of adolescents. This was done by promoting the adoption of a preventive health model among all segments of the health care system.

The MDH also provided leadership and technical assistance to the Metropolitan Health Plan in its Public Health Collaborative on Adolescent Health Care. The goal of this collaborative was to increase the demand for annual preventive health visits for adolescents among teens, parents and health providers.

C. Children with Special Health Care Needs

NP #1 - The percent of state SSI beneficiaries less than sixteen years old receiving rehabilitation services from the MCSHN program

Almost no SSI eligible children are dually enrolled in the MCSHN treatment program. Children on SSI in Minnesota are eligible to apply for MA at their county family service agency. Almost all who apply are eligible and can access a comprehensive set of MA benefits which exceed the benefits available to them from MCSHN.

MCSHN's role with this population is to inform families of their child's probable MA eligibility and services they can receive if eligible. MCSHN provides them with information on MA, MA benefits and MCSHN's Toll free Information and Assistance line if they have questions. It then becomes their choice whether or not to apply. In addition, the program will continue to work with SSA to receive the names of those children who do not qualify for SSI and target these children for outreach regarding MCSHN. MCSHN continues to work with the state medicaid program regarding changing Minnesota's 209B status to allow linking of medicaid and SSI eligibility.

MCSHN assisted families in applying for MA by providing application information and when necessary by contacting the county human services representatives. Outreach services were provided through letters to SSI eligible families informing them of their child's eligibility for Medical Assistance and the scope of services provided. Families were also given information on the toll free MSCHN Information and Assistance Line.

The MCSHN study of children and families who lost their SSI eligibility due to the welfare reform changes was completed. Findings from this study documented that 80% of the children were receiving MA prior to the changes and this dropped to 50% after the loss of SSI. As a result of this information DHS contacted the families and local county financial aid workers of the children who lost their MA informing

them of the changes in federal law allowing them to keep their MA eligibility. The study also found that children have twice as many diagnoses as those that made them eligible for SSI, children do have regular medical and mental health care with one physician for a more than one year, that even with more than half of the families having someone in the family employed and having access to SSI the family remained at or below poverty level, and one fourth of families who worked and accessed child care paid extra. In addition, as a result of this activity many families were informed about the SSI appeal process as well as other services available to their child and family.

NP #2 - The degree to which MCSHN provides or pays for specialty and sub-specialty services, including care coordination not otherwise accessible or affordable to its clients.

MCSHN provided or paid for the nine specialty and sub-specialty services related to NP #2 either through its field clinics or payment for services to care providers treating children enrolled in its treatment or evaluation programs. This number has not unchanged since the 1996 base year.

During SFY 99 there were 2,177 children enrolled in the MCSHN treatment program and 722 in the diagnostic evaluation program. Children enrolled in the treatment program received a Minnesota Health Programs Card allowing them access to primary, specialty and sub-specialty care. In 1999, MCSHN's nine different types of field clinics had 1,191 children attending 156 clinics at 37 sites. In addition to providing consultative services to children, families, and professionals in greater Minnesota, MCSHN clinics provided unique educational opportunities for local health professionals and university or major medical center graduate students, fellows, and residents.

Care coordination is not provided directly by MCSHN staff, but is provided by some local Community Health Boards through the Title V MCH Special Project grants and other state and local dollars. 6,429 children received service in CY99. MCSHN staff provided consultation and technical assistance regarding case management/care coordination best practices as part of MCSHN's assurance function of core public health activities.

ENABLING SERVICES

Minnesota Statute requires that two-thirds of the federal MCH Services Block Grant, supplemented with state dollars, be allocated through Maternal and Child Health Special Projects grants to local Community Health Boards. These funds are a major source of revenue for local enabling services including transportation, translation, outreach, respite care, health education, family support

services, case management/care coordination, and collaboration with other agencies which provide related services.

A. Pregnant Women and Infants

NP#15 - Percent of very low birth weight live births.

The rate of very low birth weight live births declined slightly, from 1.12 in 1997 to 1.07 in 1998. The annual performance objective has been met.

Local Community Health Boards carry out a variety of activities aimed at decreasing the number of low-birth weight and very low-birth weight births. Many CHB offered free pregnancy testing with a public health nurse who made an initial assessment, educated and counseled about healthy behaviors in early pregnancy and referred women for appropriate services. Women who were at high-risk and income eligible at below 200 percent of poverty or Medical Assistance eligible were enrolled in improved pregnancy outcome services. These services included public health nurse home visits which focused on assessment, monitoring, nutritional counseling, prenatal education, prevention of preterm birth education, case management and follow-up. Early identification of high-risk, low-income pregnant women was also promoted at WIC clinics, medical clinics, schools, social services, migrant health services and other locations. In 1999, 8,261 women were served by the MCH Special Projects improved pregnancy outcome program.

CHB make an effort to reach diverse populations. Print, videotapes, and other media material as well as clinical practices were modified to meet the cultural expectations and language needs of the populations in the service area. Workshops that addressed cultural health practices and beliefs were made available to staff. Interpreter services were available for home visits, community outreach and education. Activities at the local level included enabling services such as provision of transportation, translation, outreach, health education, family support services, case management and coordination with WIC clinics.

Support for the CHB program was provided through a two day workshop entitled “Cultural Competency for Public Health Professionals” sponsored by the Office of Minority Health and the Public Health Nursing Section. One of the primary goals of the workshop was to develop leadership skills in facilitating cultural competency among public health nurses.

NP#18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first

trimester.

The percent of infants born to pregnant women receiving prenatal care beginning in the first trimester increased slightly, from 84.1 percent to 84.5 percent. The annual performance objective of 86.9 percent was not met. According to the April 29, 1999 Monthly Vital Statistics Report (Vol. 47, number 18), 31 states had better rates for this measure than Minnesota for non-Hispanic white women (dropping from 29th in 1997). Minnesota's national ranking for African American women was third worst for this measure, and second worst for Hispanic women. Minnesota's efforts to improve early initiation of prenatal care need to be broadly inclusive, but African American and Hispanic women should be specifically targeted with culturally appropriate interventions to reduce their larger disparities.

CHB activities promoted the initiation of prenatal care in the 1st trimester. Many offered free pregnancy testing (6,216 tests provided in CY 1999) with follow up by a public health nurse who made the initial assessment, educated and counseled about healthy behaviors in early pregnancy and referred women for appropriate services. Women whose pregnancy test was negative were also counseled regarding family planning and healthy pre-pregnancy practices.

Outreach activities are fundamental to increase the number of women who begin prenatal care in the 1st trimester. CHB staff throughout the state are skilled at initiating and maintaining collaborative relationships with other community organizations frequented by women of childbearing age. CHB promoted such messages through collaborative agreements with area health clinics, hospitals, extension services, social services, schools, Head Start programs, and early child and family education programs. By reinforcing the importance of early pregnancy identification and referral as well as healthy life styles to community-based organizations and the women they serve, the opportunity for impacting attitudes and behavior is increased.

B. Children and Adolescents

SP #2 - The percentage of children and adolescents enrolled in health plans who receive comprehensive preventive health visits according to nationally accepted standards.

Please refer to the previous description of SP #2 data and interpretation.

Please refer to the previous SP #2 narrative concerning Minnesota's EPSDT program, Child and Teen Check-Ups (C&TC), which provides comprehensive preventive health visits to the Medicaid population. The program also provides a strong outreach component. Title V agency staff enhanced the outreach component of the C&TC program by providing technical support to local C&TC Outreach Coordinators, participated in regional C&TC outreach meetings with Outreach Coordinators and health

plan representatives, and participated in health plan and county sponsored regional meetings for C&TC providers.

State law permits only Minneapolis and St. Paul to use MCH Special Project funds for general adolescent health Services. Both cities use the funding to support school-based clinics which in 1999 served 6,668 youth. Further, Minneapolis contracted with the Neighborhood Health Care Network, a community clinic umbrella association to provide enabling services to children and youth within community-based clinics in Minneapolis. These services included assistance with transportation, interpreter services and outreach services to adolescents. In CY 1999 12,699 persons were served.

C. Children with Special Health Care Needs

NP #3 - Percentage of children with special health care needs with a medical home.

During 1999 the MCSHN program began surveying all families enrolled in the Minnesota program. The AAP definitions for accessibility, continuity, comprehensiveness and coordinated care were used to define a medical home. The denominator is the number of families enrolled in the MCSHN program and the numerator is the number of those families who responded affirmatively to the definitions of the four criteria above. 78.6 percent said care was continuous, 68 percent said it was continuous and accessible, 61 percent said it was continuous, accessible and comprehensive and 25.5 percent said it was continuous, accessible, comprehensive and coordinated.

Minnesota has a complex system of health care coverage for children with special health care needs including Medical Assistance, MinnesotaCare, fee-for-service, and managed care. Although insurance coverage does not assure that a medical/health home is established, it does assure that families have access to medical/health care. The Title V program assisted families in several ways: (1) MCSHN intake and referral staff assisted families calling the 1-800 referral line in applying for Medical Assistance or MinnesotaCare, as appropriate; (2) MCSHN paid insurance premiums for 98 families, thus assuring that lack of health coverage was not a barrier to services; and (3) the MCH Special Projects grants program authorizes services to children with special health care needs as one of the statewide priorities. In 1999 6,429 children were served.

D. Enabling Services Affecting All MCH Populations

SP #8 - Percentage of MCH plans that include objectives and methods to eliminate the disparity in health status between populations of color and the majority population.

Although the performance measure was 100 % achieved, applicants and application reviewers both

concluded that better information was needed to measure disparities and there was a need to better address disparity interventions. Given that one of the five Strategic Directions of the Department is elimination of disparities this will be further addressed by various programs including Title V.

State law requires that two-thirds of the federal MCH block grant allocation, supplemented by an appropriation from the state general fund, be distributed to Minnesota's Community Health Boards as Maternal and Child Health Special Projects grants to provide a focal point for core MCH infrastructure and resources for population based services. Application instructions for the CY 2000-01 grant cycle, directed each agency to address the following three questions on efforts to reduce racial disparities: 1)"Describe how the CHS needs assessment used available data to analyze the extent to which the CHS area has disparities in risk factors and health status between MCH populations of color and the majority population." 2)"Within the populations to be provided services by the MCHSP during CY 2000-01, what racial/ethnic disparities were identified?" 3) "What strategies and objectives have been established to reduce significant disparities? Of particular interest are community and systems strategies/objectives which recognize the potential role all types of community-based organizations can play in the decrease of disparities?"

All 49 applications responded to these questions. Not all agencies have significant numbers of populations of color within their respective jurisdictions (county or multi-counties), but of those that do, all of them responded with strategies and objectives to reduce racial/ethnic disparities.

POPULATION-BASED SERVICES

The population-based services activities which are described below relate mostly to state agency Title V activities which support local screening, and public education activities that are generally funded by non Title V sources.

A. <u>Pregnant Women and Infants</u>

NP #4 Percent of newborns in the state with at least one screening each for each of PKU, hypothyroidsim, galactosemia, hemoglobinopathies.

In 1998, 98.7% of the state's newborns were tested by the state's newborn screening program. This is unchanged from the previous year and is short of the performance objective of 100%. Reasons for not being screened included parental refusal at birth, and hospital discharge before 24 hours of age.

Pursuant to state statute, all newborns must be screened for phenylketonuria (PKU), congenital hypothyroidism, congenital adrenal hyperplasia, galactosemia and hemoglobinopathies.[69] The Newborn Screening Program tests samples taken from neonates and tracks the results of confirmatory testing of presumptive positive samples. This program is operated as a partnership of the Title V program (MCH & MCSHN) and the Public Health Laboratory Division.

Accomplishments for 1999 include designing the newborn registry of confirmed cases to link it directly with the newborn screening database for improved tracking and reporting of confirmed cases. An additional staff person was hired to coordinate these tracking and follow-up activities and to identify strategies to improve community collaboration. The specialist/center referral resource list was continuously updated and shared with medical home providers and families. The new Newborn Screening Follow-up Specialist participated in a Region V conduct to accomplish peer review of newborn screening programs. Within the Department, collaboration has increased between the Newborn Screening Program and Title V program which has resulted in improved services for children with metabolic abnormalities and their families.

NP#5 - The percentage of children through age 2 who have completed immunizations for measles, mumps, rubella, diphtheria, tetanus, pertussis, haemophilus influenza, hepatitis B.

In Minnesota there were 70 new cases of hepatitis B in 1998, and 80 new cases in 1999. Of those new cases, there were 4 newborns in 1998 and 8 newborns in 1999 who tested positive. Of the 8 newborns in 1999, 7 were perinatal transmissions; one was an adopted infant from Eastern Europe who tested positive after arrival.

In 1999, 269 HBsAg positive women were reported to MDH. A total of 274 infants were born to these women; 5 of the women delivered twins. Out of the 274 infants, 269 (98%) received Hepatitis B Immune Globulin (HBIG) and hepatitis B vaccine dose #1 (HBV1) at birth; 4 additional infants received only HBV1 several days after birth; and 253 (94%) received HBV1 and HBV2. To date, 139 (52%) have completed the three dose series. However, many infants born later in 1999 are not yet due for their third dose, so this percentage will rise over the coming months.

The Title V program is not the lead agency for immunization activities in Minnesota. Rather, the Acute Disease Prevention Services in the Disease Prevention and Control Division at the Minnesota Department of Health plans, implements and evaluates immunization activities. Title V staff collaborate in these activities.

Since 1988 the United States Public Health Service Immunization Practices Advisory Committee (ACIP) has recommended that all pregnant women be screened for hepatitis B surface antigen (HBsAg). The Minnesota Department of Health implemented a hepatitis B perinatal prevention program in 1990 with funding from the Centers for Disease Control and Prevention.

Changes to Minnesota's School Immunization Law will make hepatitis B shots a requirement for school enrollment starting with kindergartners in the 2000-01 school year. Grade seven will be added in school year 2001-02.

NP #9 Percentage of mothers who breastfeed their infants at hospital discharge.

In 1998, 72.5 percent of the state's infant population and 59.9 percent of the low-income infant population were breastfed, a change from 72 percent, and 60.5 percent respectively in 1997. Thirty-seven percent of the infant population and 22 percent of the low-income infant population were breastfed to 5 - 6 months of age, an increase from 30 percent and 20 percent in 1997. [70] Breastfeeding initiation rates for some special population groups, especially refugee populations, are lower, as low as 20 - 30 percent in the Southeast Asian population. Direct service staff have reported the Somali population is also ceasing to breastfeed upon immigration to the United States. While progress has been made in addressing barriers to breastfeeding, numerous barriers remain.

The Division of Family Health, in 1996, created a special project team devoted to breastfeeding promotion which included Title V participation. The team recommended creation of the Lactation Friendly Workplace Program. This program helped establish 74 lactation rooms in businesses throughout the state, thus addressing the important barriers breastfeeding women face when they return to work. In addition there have been numerous businesses around the state seeking information from MDH to help them set up a "lactation friendly" workplace. Title V funds helped fund a breastfeeding special projects coordinator position to consult with businesses helping them to understand the importance of supporting breastfeeding employees and aiding them in the set up of lactation rooms. Funding for this position ended in October 1999, and the breastfeeding special projects team has disbanded.

Members of the team also worked to implement the "Loving Support Makes Breastfeeding Work" media campaign in Minnesota, with an initial $10,000 in seed money from the MCH Block grant. Currently four outdoor bulletins will rotate through the 11 county metropolitan area for one year, funded by WIC and UCare Minnesota. In addition Eller Media provided public service space worth $160,000.

The toll free phone number "877-214-BABY" is used with the outdoor campaign, to provide callers with sources of breastfeeding information in their communities.

The Minnesota WIC program has implemented multiple activities to promote and support breastfeeding. Some of the WIC activities also reach other portions of the MCH population.

NP #10 - Percentage of newborns who have been screened for hearing impairment before hospital discharge.

By the end of 1998, 14 hospitals had implemented UNHS programs. These hospitals represented approximately 22 percent of Minnesota births. By year end 1999, 34 hospitals including 6 NICU units and representing 40% of Minnesota births had implemented UNHS programs. In addition, approximately 30 hospitals have reported that they began the process of planning for UNHS programs in 1999. These hospitals include several large birthing facilities and represent 48% of the births in the state.

In early 1998 Title V staff presented a report to the legislature entitled *A Voluntary Implementation Plan for Universal Newborn Hearing Screening (UNHS)*. Title V staff and staff from the Department of Children, Families and Learning plus local and state stakeholders began implementation of the plan's seven objectives in 1998 and in 1999 continued to promote the program, and offer technical assistance in the state. Presentations were made to several hospitals, infant follow-along coordinators, public health nurses, audiologists and educators about UNHS. Several grand rounds presentations were also made. Surveys were conducted of state audiologists, IEIC teams and 120 hospitals to determine interest in implementing UNHS.

The Department has been awarded a federal SPRANS grant beginning in 2000 which will significantly boost Title V capacity to support achievement of the goal of universal screening.

SP#6 Percent of women who use alcohol, tobacco, and other drugs during pregnancy.

The percent of women reporting smoking during pregnancy has steadily declined from 13.1 in 1996, to 12.9 in 1997 and to 12.39 in 1998. The annual performance objective of 12.58 percent was exceeded. Although the rate decline has been sustained for two years, the number of pregnancies for which data is missing increased from 4 percent in 1996 to 5.9 percent in 1997 and to 7 percent in 1998. This trend needs continued monitoring. See Form 16, SP #6 for further discussion of data issues.

Title V staff have been involved in a number of activities intended to reduce alcohol, tobacco, and other drug use during pregnancy:

Minnesota Pregnancy Assessment Form

The Minnesota Pregnancy Assessment Form (MPAF) is the result of a collaborative process in which the Minnesota Council of Health Plans, the Minnesota Department of Human Services, the Minnesota Department of Health, the Minnesota Medical Association, and community experts participated. The form asks providers to assess medical and psychosocial factors that contribute to poor birth outcomes. Among the 40 items assessed are questions regarding tobacco, alcohol, and/or other drug use during pregnancy.

Since June 1998 the Department of Human Services has required all pregnant women covered by Medical Assistance and/or MinnesotaCare to be screened using the (MPAF) to be reimbursed for prenatal care services. It is estimated that of the 19,374 births per year covered by Medical Assistance, nearly all are screened prenatally using the MPAF. MCH staff were actively involved in the development and implementation of this tool.

Collaboration with Tobacco Control Program

Within the Bureau of Family and Community Health, the MCH staff work collaboratively with the Tobacco Control Program staff. Staff met periodically to discuss the issues of tobacco use among women, including pregnant women and the effects of tobacco use on women's health, pregnancy, and birth outcomes. The recommendations from MCH's Ad Hoc Committee on Fetal & Infant Mortality Reduction included reducing tobacco use by pregnant women and exposure to environmental tobacco smoke, and increasing smoke-free childcare environments. These recommendations fit the Department's Strategic Direction to reduce tobacco use and improve the health of Minnesota's youth. MCH staff are working with the American Cancer Society and local public health agencies to implement the Make Yours a Fresh Start Family, an evidence based smoking cessation intervention program.

Fetal Alcohol Syndrome

The 1998 legislature created a Fetal Alcohol Syndrome Coordinating Board[71] which established seven strategic priorities, including review of state agency programs related to FAS; promotion and support of research, analysis, and evaluation to establish a set of best practice standards for the prevention and treatment of FAS; promotion and training consistent with such standards; provision of effective advocacy for public policy on FAS/FAE and related public health goals; increase public awareness about FAS/FAE; engagement of the private sector, especially HMOs and the beverage industry, in FAS-related activities;

and sponsorship of demonstration projects within the juvenile justice

and child welfare systems. Although the Board no longer exists, its vision continues as a framework for other agencies' activities.

In 1999 MDH designed a Prenatal Alcohol Survey to be sent to each primary care physician in the state. The survey will assess physicians' opinions, knowledge base, practices and needs surrounding the issue of alcohol-related birth defects. A similar survey will be sent to nurse-midwives in the state.

Twelve state-wide nonprofit agencies were funded for prevention activities targeting pregnant women and to expand local service networks for individuals and families coping with FAS and other alcohol-related birth effects. Regional workshops of FAS grantees meet regularly to address gaps and needs. A summer institute for all DHS, MDH, and DCFL FAS grantees was held in July 1999 to provide opportunity for networking, capacity building, and future planning and coordination of efforts.

An educational video tape with study guide for students in health professions and practicing health professionals was developed. The video and self-learning tools are aimed at developing skills to screen pregnant women for alcohol use and abuse. In addition, regional circulating libraries, medical, and nursing schools have been supplied materials for loan.

The multimedia public awareness campaign ("Don't Take the Risk; Don't Take the Drink") launched in 1998 is currently being evaluated for effectiveness. Media materials are being revised to better target African-Americans, American Indians, Asians, and Latinos.

MCH staff were involved in developing materials for health professionals, reviewing the educational video and self-learning packet, and editing the Prenatal Alcohol Survey for nurse-midwives. MCSHN has had a lead role in establishment of the diagnostic clinics.

CISS Project

The Family Health Division's Community Integrated Service Systems (CISS) Project is entering its last (4th) year of funding funded through the Maternal Child Health Bureau. It is administered in a collaborative approach which includes MDH participation from MCH, Community Health Services and Center for Health Promotion sections of the Department. The collaboration also includes partners outside of the MDH, e.g. local public health agencies, managed care representatives, school health, State Departments of Children, Families and Learning and Human Services. The purpose of the project was to provide a model for integrating clinic and community-based prevention services for alcohol and tobacco use among youth, including pregnant youth.

It has been difficult to convey the value and need for blending community service systems using the

term “community integrated service systems”. Consequently we have begun using the phrase–“building productive community connections” which has led to a greater understanding of the project’s intent. The project model has been piloted in four demonstration sites in Minnesota. The four sites were very different in organizational leadership, membership and service area. Using pre and post test evaluation tools and informational interviews, lessons were documented that will be valuable to share with other local community groups.

Building Productive Community Connections is the central message portrayed in the tools developed. Examples of the tools are: A community-based prevention wheel, Promising Practices for Guiding Screening, Brief Intervention, Referral and Follow-up activities among youth in a community setting, and Community-based Planning Tools which have been adapted for Tobacco Prevention, and Cessation, and an Alcohol Youth Message Campaign. The Tobacco Community Planning Tools are available on the web at www.health.state.mn.us/topics, click on tobacco prevention.

Child and Teen Checkups

In CY 1999 the Title V Child and Teen Checkups staff provided six C&TC training sessions with instruction on performing a health history. The health history instruction specifically addressed questions regarding alcohol, tobacco and other drug use during pregnancy. In addition, staff collaborated with the Department of Human Services, the Department of Children, Families, and Learning, and the University of Minnesota to develop a new health history form for children ages 3-5. This new form includes questions regarding family alcohol, tobacco and drug use. In the spring of 1999, these agencies collaborated to provide five regional training sessions to inform and promote the use of the new health history form to over 600 early child health professionals.

B. <u>Children and Adolescents</u>

NP#5 The percentage of children through age 2 who have completed immunizations for measles, mumps, rubella, diphtheria, tetanus, pertussis, haemophilus influenza, hepatitis B.

The 1998 - 99 Retrospective Kindergarten Survey, conducted by MDH, estimated the immunization rates of currently enrolled kindergartners when they were 2 years of age (1994-95). Results indicated that 74.0 % (+/- 3.3) had received 4 DTP, 3 polio and 1 MMR by age two. Birth date range for this survey was 1992 - 1993.

Data from the most recent Centers for Disease Control and Prevention (CDC) National Immunization Survey (July 1998 - June 1999) indicated that the percentage of 19 - 35 mo olds in MN with

4 DTP, 3 polio and 1 MMR was 82.2% (+/- 4.9). The birth date range for this survey was August 1995 - November 1997.

The federally-funded Vaccines for Children (VFC) program began on October 1, 1994, with a goal of ensuring affordable vaccines for all children. The Acute Disease Prevention Services Section of the Disease Prevention and Control Division has developed an enhanced version of the program which is called "MnVFC". The MnVFC program utilizes federal VFC funding to supply vaccine at no cost to participating providers to be administered to uninsured children and also utilizes federal 317 funding to provide vaccines to children whose insurance requires deductibles and/or co-pays for immunizations as well as vaccine for in-school clinics.

Minnesota legislation requires that all clinics that serve clients under a Minnesota Health Care Program (MHCP) such as Medical Assistance, MinnesotaCare, or General Assistance Medical Care be enrolled in the MnVFC program.

The Title V program is not the lead agency for immunization activities in Minnesota. Rather, the Acute Disease Prevention Services in the Disease Prevention and Control Division plans, implements and evaluates immunization activities. Title V staff collaborate in these activities.

Last year the Title V Child & Teen Check-Up program provided seven C& TC training sessions to public and private providers with instruction and updates as presented by the Immunization Unit of the Division of Disease Prevention and Control.

NP#6 - The birth rate for teenagers aged 15-17 years.

The birth rate for teens age 15 to 17 declined from 18.5 to 16.8 in 1998. The performance objective was exceeded.

Family Planning

Both Title V and state funds are expended for family planning public education. In 1999, Community Health Boards expended Title V funds to provide family planning counseling and education services to 13,235 people. 34,435 persons received health education in group settings.

State dollars support the Family Planning Special Projects (FPSP) grant program. These funds are available to Community Health Boards and non-profit corporations to provide pre-pregnancy family planning services. Sixty-two (62) applications from agencies and one Statewide Hotline were funded for the calendar years 1998-99 grant cycle. A total of $10,635,295 was awarded. In 1999 the FPSP grant program served 37,359 women for family planning counseling services. Forty percent of persons served

were 19 years old and younger. In 1999 the Family Planning Hotline provided information and referral services to 6,067 people state-wide, of these 1,485 were 19 years old or younger.

MN ENABL

The MN ENABL (Education Now and Babies Later) program utilizes a multi-faceted, primary prevention, community health promotion approach to reduce adolescent pregnancies. It is targeted to 12-14 year olds, their parents and other primary care givers, and their communities, including schools. Twenty four community-based projects participated in the program in 1999. They represented both urban and rural areas and served a diverse group of adolescents. Grantees include school districts, nonprofit organizations, and a family service collaborative.

The program has five major components: community organization activities which are implemented by collaborating with community groups and interested persons to reinforce the MN ENABL message; the *Postponing Sexual Involvement* (PSI) curriculum which is available to adolescents ages 12-14; a media campaign which promoted the message using television and radio PSA's, posters, t-shirts, water bottles and other promotional items; training and technical assistance for community-based projects; and an evaluation of state and local MN ENABL activities. Approximately 5,243 teens received the PSI curriculum in 1999 compared to 4,000 in 1998.

Abstinence Education

The Minnesota Abstinence Education Community Grant program is supported by Section 510 of Title V of the Social Security Act. The program utilizes a multi-faceted, primary prevention, community health promotion approach to reduce adolescent pregnancies and to promote a standard of abstinence for youth age 14 and under. Fourteen local communities were awarded funds to continue the program to December 31, 2002. Grant recipients include school districts, Community Health Services, and private-nonprofit organizations. The program has five major components: community organization activities which involve collaborating with community groups and interested persons to convey and reinforce the message of abstinence for youth ages 14 and under, implementation of one of four state-approved curricula, local media activities, training and technical assistance for community-based projects, and an evaluation of state and local program activities. The four curricula available for grantee use include *Postponing Sexual Involvement, Managing Pressures Until Marriage, Worth the Wait* and the *Abstinence Curriculum*. Most grantees are utilizing either *Postponing Sexual Involvement* or *Worth The Wait*. Approximately 4,083 youth received one of the curricula in 1999.

African-American Teen Pregnancy Initiative

This project is being carried out by the Department's Office of Minority Health in collaboration with community partners. Minnesota currently has one of the highest pregnancy rate in the country for African American teens. The project's goal is to reduce the pregnancy rates for African American teens by evaluating their risk factors, providing this information to the community, and creating a collaborative effort to better focus pregnancy prevention and intervention services.

In 1999 a symposium was held which focused attention on the continued high pregnancy rates for African American teens in Minnesota. It addressed the need for realignment of resources and programmatic efforts to improve teen pregnancy prevention outcomes. Also, community driven strategies and models that have successfully impacted the teen pregnancy rates were explored. In addition, the symposium was the first step in creating a community driven collaborative to address the systemic changes needed to successfully impact the African American teen pregnancy rates. The goal for the collaborative is to address policies that will impact programmatic efforts for teen pregnancy prevention efforts in the African American teen population. A facilitator was hired to conduct the collaborative meetings. The time line for the collaborative is to have an action plan ready to implement by April 2000. Title V staff are actively involved in this project.

NP#7 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

The percent of Medicaid-eligible children receiving protective sealants has fluctuated over the last three years, remaining consistently short of the performance objective however. Most states, including Minnesota, are currently able to provide data related to national performance measure #7 for the Medicaid population only. Strategies related to better data collection for national performance measure # 7 were discussed at a meeting of the State Dental Directors in June 1998.

The Division's oral health program provided oral health training, technical consultation, and educational materials to Community Health Boards, schools and the general public. This program also worked with the Department of Human Services in areas of dental policy and access issues. The C&TC staff provided six training sessions that included discussions of dental sealants and dental assessments.

NP #8 - The rate of deaths to children 1-14 caused by motor vehicle crashes per 100,000 children.

The rate of deaths to children age one to 14 rose, from 3.8 per 100,000 in 1996 to 4.5 per 100,000 children of this age group. This trend parallels a concomitant rise in overall traffic fatalities in Minnesota during this period. This rise may be associated with higher speed limits, but may also be associated with a

higher percentage of traffic fatalities involving alcohol.

During 1999 the two Title V supported activities related to reducing risk of injury in a motor vehicle-related crash included continued statewide collaboration with Minnesota SafeKids and the Department of Public Safety to distribute car seats to those who needed but could not afford them. This effort was combined with intensive training of child seat distributors about the importance of correct installation of the car seat along with the necessity to use a car seat or seat belt every time one is in a motor vehicle. Through the MCH Special Projects grant program which addresses injury control as a statewide priority, Title V funding also supports local activities in this regard. In 1999, 6,501 Minnesota children benefitted.

The C&TC program provided six training sessions to C&TC providers in CY 1999 that included anticipatory guidance on safety issues including car seats and seat belt use.

SP #4 - Incidence of substantiated child maltreatment by persons responsible for a child's care.

Substantiated child maltreatment by persons responsible for a child's care rose slightly, from 8.18 to 8.62 incidents per 1000 children age 0 to 17 between 1996 and 1997 and then declined to 8.39. The performance objective of 8.18 was not met.

Child maltreatment has been identified as an important public health issue in the *Minnesota Public Health Goals* and its associated strategies document. This work serves as a guide to communities, health plans and others committed to improving public health. This information, along with strategies to achieve the objective of reducing child maltreatment, has been disseminated through statewide training and technical assistance to local public health agencies.

Home Visiting Programs for the Prevention of Child Maltreatment

The Home Visiting Program to Prevent Child Abuse and Neglect was established by the 1992 Minnesota Legislature to promote positive parenting, resiliency, and a healthy beginning for children. The program provides grants and technical assistance to local public health agencies for expansion of public health nurse home visiting to offer early intervention services for at-risk families. Grants also assist local public health agencies to strengthen and enhance their current array of services for families and to develop a coordinated, community-based approach to the prevention of child maltreatment. To date, twenty Home Visiting Projects have been implemented, serving families in 23 counties and one Native American Reservation.

Minnesota Healthy Beginnings

The Minnesota Healthy Beginnings (MHB) program, established in 1997 by the Minnesota Legislature, is a universally-offered home visiting program for expectant parents and parents with new babies. MHB is offered to all new parents prenatally or as soon as possible after birth, irrespective of income or risk status to strengthen families and promote positive parenting and healthy growth and development. A PHN assessment occurs during the first home visit with subsequent visits by PHNs and/or other trained home visitors to provide information, support and linkages to community resources based on family interests and needs. In 1999, the program awarded five-year grants (CY1999 to 2003) to four local agencies whose combined average annual resident births was 2,346. MHB staff coordinated a home visitor training program and provided ongoing technical assistance to the local grantees.

NCAST Training

In CY 1999 three Nursing Child Assessment Satellite Training (NCAST) sessions were provided to MCH public health nurses by Title V staff. NCAST training offers health professionals in-depth training in the use of caregiver-infant/child interaction assessment scales. Scales included in the training are the NCASA (Nursing Child Assessment Sleep/Activity), the HOME (Home Observation for Measurement of the Environment), the Feeding Scale, and the Teaching Scale. These scales are a reliable and valid means of observing and rating caregiver-infant/child interaction for the purpose of assessing whether the caregiver and child have problems in their interaction and communication pattern. NCAST's reliability and validity are recognized by the legal system and are often used in managing child abuse or neglect cases.

SP #9 - Proposed New State Performance Measure Related to Youth Risk Behavior Reduction

As described in part III of this document, the needs assessment process resulted in the formulation of ten priorities. Nine of the ten priorities relate to the current 18 core performance measures or 8 state performance measures. The priority "Reduce youth risk behaviors" does not. This issue was raised at the June 23 meeting for public input. It was recommended that a ninth state performance measure be developed related to this priority for inclusion in the FFY 2002 application.

The Youth Risk Behavior Endowment is a new Minnesota Department of Health initiative that will give local public health agencies an opportunity to address a broad range of youth risk behaviors and the risk and protective factors that influence these behaviors. The targeted risk behaviors include alcohol and other drug use; sexual behaviors that may result in pregnancy, HIV and STDs; violence; suicide; physical inactivity; and unhealthy dietary behaviors. Funding for this initiative is provided through the Tobacco Prevention and Local Public Health Endowment established during the 1999 legislative session. Funding

will be provided to all Community Health Service agencies through non-competitive grants. Funding for the first year (July 1, 2000 - June 30, 2001) will be $2.0 million growing to approximately $5 million in 2003.

Department staff, in conjunction with a workgroup of local policy makers, public health administrators and staff, have developed a framework to assist local agencies in understanding the context in which youth risk behaviors occur, and to guide the implementation of this initiative. The framework is grounded in beliefs in the interrelatedness of physical and emotional health of youth and in the value and potential of youth as resources to be developed rather than problems to be fixed. The framework encourages a community-wide approach, using effective youth risk reduction and protective approaches and strategies to support the healthy development of youth. The framework requires the active involvement of youth in each stage of planning and program implementation. Plans are proceeding to the provision of technical assistance to local public health agencies to support their planning efforts.

C. Children with Special Health Needs

The national and state performance measures do not include a population-based measure specific to children with special needs. However, MCSHN does provide several population-based services for the CSHN population and their families, including: workshops to explain health care insurance and funding options to families; parent information packets providing information on financing, community resources and parent support; and workshops for providers.

D. Population-Based Services Affecting All MCH Populations

SP #3 - Incidence of injury (violence/unintended; fatal/non-fatal) to all MCH populations

Previously we reported that the summary injury impact score fell from 241 (1996) to 186 (1997) to 182 (1998). However, the summary impact score was revised to 304 in 1998, the first year for which MDH has had accurate, comprehensive, statewide data available for analysis. In the previous years, MDH estimated total injury hospitalizations based on brain and spinal cord injury hospitalizations. The revised 1998 data does not represent a dramatic worsening of the performance measure. See Notes for ERP Forms 1-16, SP#3 for the basis of the calculation of this performance measure.

The Injury and Violence Prevention Unit, located within the Minnesota Center for Health Promotion, Division of Family Health, is charged with leading the state's effort to reduce risk of injury across all population and age groups in Minnesota.

Unintentional Injury

Principal activity and investment of staff resources have focused on reducing risk of unintentional injury in the home and, in particular, in homes where young children reside. *The Home Safety Checklist*, refined and evaluated in Minnesota in the early 1990s, was the primary tool used in 1999 to identify environmental risks and is the teaching tool for ongoing home monitoring. This intervention allows the promotion of the installation of smoke alarms, thus reducing risk of fire and burn injuries. The *Home Safety Checklist* also identifies those factors which contribute to falls, another significant risk of injury in the home. Other activities and resources of the Unit included support for community-based bicycle helmet promotion and emphasis upon the correct use of child restraints in motor vehicles. These activities are supported in local Community Health Boards by MCH Special Projects grants which, in 1999, for childhood injury control reported expenditures of $214,766 and 6,501 children served.

The Injury and Violence Prevention Unit provided internal staff support and material resources to support community-based intervention. An important source of support for reducing risk of unintentional injury was extended in the form of capacity building and training of local public health nurses and staff, maternal and child health nurses and staff, community advocates, and those involved with policy formulation and resource allocation at the community or county level.

Violent Injury and Violence Prevention

The Injury Unit's principal manner of addressing and responding to violence in communities across Minnesota was to train local public health nurses and allied community staff to analyze local data, assess community needs, and implement and evaluate control and prevention programs. Efforts to date have been supported by special grant or foundation funding (assessing the impact of firearm-related injury in two communities in Minnesota, and conducting community-based training.

The Injury and Violence Prevention Unit maintains the statewide Traumatic Brain and Spinal Cord Injury Registry, the state trauma data bank (a project that describes the epidemiology of hospitalized trauma), the hospital emergency department injury surveillance project, and supports other special injury or violence-related data initiatives. This capacity for data collection and analysis will generate the refined performance target goals and objectives during the next decade.

The MDH Sexual Violence Prevention Program, in partnership with the Minnesota Center for Crime Victim Services, helped to sustain the work of sexual assault programs across the state, and through the state public health system to build capacity to respond to and prevent sexual violence. Preventive Block Grant funds were specifically directed to support 22 prevention projects across the state. Activities

initiated by MDH included the development of a community-focused Sexual Violence Prevention Resource Kit, and the convening of a statewide Town Meeting on Sexual Violence, televised in the fall of 1998, and re-broadcast during 1999.

INFRASTRUCTURE BUILDING SERVICES

The one third of the state's allocation of the Title V grant is largely expended for infrastructure building services. Of the two thirds of the Title V grant allocated to Community Health Boards eleven percent (11%) is utilized for this purpose.

A. <u>Pregnant Women and Infants</u>

NP#15 - Percent of very low birth weight live birth.

The percent of very low birth weight live births has been stable at 1.1 percent. The annual performance objective of 1.10 percent has been met.

Title V staff in the Division of Family Health provided leadership and technical assistance to CHB and personnel in relation to improving systems to identify and refer women who are pregnant and at risk of poor outcomes. Activities included training for public health nurses and para-professionals in assessment and intervention skills related to domestic violence; alcohol, tobacco, and other drug use during and after pregnancy; teen pregnancy and parenting; HIV/AIDS testing in pregnancy; and the role and use of the Minnesota Pregnancy Assessment Form (described previously). Since June 1998, Minnesota providers have been required to screen using the Minnesota Pregnancy Assessment Form and to submit the form to be reimbursed for prenatal care services to Medicaid and MinnesotaCare enrollees. This has greatly improved the utilization of the assessment form. Trainings consistently emphasize the need to promote early prenatal care, screen women at initial prenatal visit, and follow-up with appropriate interventions, including public health home visits and referrals for specialized medical care. Prenatal education and counseling is stressed for all pregnant women.

In 1999, Title V staff continued to work with the Southcentral and Southwest Public Health Districts as they collaborate with managed care and local physicians to establish a comprehensive, population-based model of prenatal care. The objective of these groups is to create a standardized model for prenatal care to better assure that all women receive timely and appropriate services before, during and after pregnancy. Staff also aided in evaluation design and data system development. The intent is to create a system that can be used statewide.

Fetal Infant Mortality Review Projects

The Infant Mortality Reduction Initiative was established by the Minnesota legislature in 1989. Several studies and projects have been funded under this initiative.

Project LID (Lower Infant Deaths), conducted 1996 through 1998 reviewed 116 randomly selected infant (under one year old) deaths to residents of Hennepin and Ramsey Counties that occurred during a twelve-month period in 1996 and 1997. Project staff released their report, *Lowering Infant Deaths: Promoting Change to Save Lives*, in October, 1998. It has been widely disseminated locally, statewide, and to interested people and organizations nationwide and is a basis for significant local follow-up activity. Poster presentations on Project LID were made at the American Public Health Association annual meetings in 1997 and 1999.

The Southeast Minnesota Fetal-Infant Mortality Review (FIMR) project case review teams reviewed 98 fetal and infant (up to age two years) deaths to residents of eleven counties in the southeastern corner of the state that occurred between May, 1996, and June, 1998. The project is collaborating with public health agencies as well as other public and private agencies throughout the eleven-county area. Local community advisory committees are implementing regional priority projects and also disseminating recommendations for region-wide systems changes.

A South St. Louis County and Fond Du Lac Reservation FIMR project is collaborating with the local Child Mortality Review Team to review all fetal and infant deaths (up to age two years) that occurred in 1998-1999.

A Statewide Ad Hoc Committee on Fetal and Infant Mortality Reduction was established in 1997 to advise MDH on priorities and implementation strategies for selected systems change recommendations which were developed by past and currently-funded FIMR and other projects for improving Minnesota's pregnancy outcomes. This group completed and submitted a report to the Commissioner of Health in the fall of 1999. With the Commissioner's support, these recommendations were disseminated to MDH's partners initially through the publication of the *Healthy Minnesotans Update*, Winter issue, 2000, titled *Infant Mortality in Minnesota.* They will also be implemented in various Department staff work plans for 2000 and after.

Twin Cities Healthy Start (TCHS)

Building on the work of Project LID and other activities, the Minneapolis Department of Health and Family Support, applied for and received a grant from the federal Maternal Child Health Bureau for the Twin Cities Healthy Start (TCHS) project. The state Title V Infant Mortality Consultant was an active partner in development and implementation of this project. TCHS targets the long term disparity in infant

mortality experienced by African American and American Indian families in Minneapolis and St. Paul. It is using four models of the Healthy Start program: Consortium, Outreach, Case Management, and Enhanced Clinical Services. Consortium membership was built upon the original Project LID community partnerships and added many more community and consumer partners representing the

affected populations. The Outreach, Case Management, and Enhanced Clinical Services models are using findings and recommendations from Project LID in their design and implementation.

Perinatal Care Coordination Services

An additional initiative to emerge from Project LID is the Perinatal Care Coordination Survey. This was undertaken by MDH and the Minneapolis Department of Health and Family support to develop a common understanding of perinatal care coordination in the Twin Cities metro area. Public health nursing agencies, community health centers, managed care organizations and hospitals were surveyed to answer several questions e.g., what services exist, are they based on risk assessment, do they address barriers to care, and are they comprehensive, coordinated, and culturally competent. The survey findings will be presented to a colloquium of participants who will then develop recommendations to improve these activities in the community. Preliminary findings strongly suggest funding needs to be increased for services that address social and behavioral risk factors and barriers to care.

REACH (Racial and Ethnic Approaches to Community Health)

An additional approach to the disparity in infant mortality affecting American Indian and African American families is the REACH project, a planning grant awarded to the Minnesota Department of Health (MDH) by the federal Centers for Disease Control and Prevention (CDC). African American infants die at rates 2 to 3 times greater than White infants. American Indian infants die at rates 3 to 4 times greater than White infants.

REACH has provided one year of funding for an innovative planning process to develop a Community Action Plan of best practices to eliminate the disparity in infant mortality by 2010. The Title V program, in collaboration with the Office of Minority Health, is providing fiscal management and facilitation to a Steering Committee of community organizations that primarily serve African American and American Indian families in Hennepin and Ramsey Counties, the project's target area. In July, 2000 the Community Action Plan of best practices will be submitted to the CDC as a grant application for four years of implementation funding.

NP#17 - Percent of very low birth weight infants delivered at facilities for high risk deliveries and neonates.

There were 695 births of infants weighing 1,500 grams or less. 644 of these births at a known facility and 87.4 percent of these births were delivered at a hospital with at least 26 deliveries of VLBW infants during the year.

MCH staff have obtained from the birth certificate, the number of very low birth weight live births as well as the hospitals where these infants were delivered. However, analysis of this data is dependent on the existence of a generally recognized community standard of care for referral. Specifically, providers of prenatal care in Minnesota do not appear to have reached a professional consensus regarding indications for referral of women at high risk for very low birth weight deliveries to appropriate facilities. Moreover, the definition of appropriate facility is not commonly agreed upon by all providers. Consensus regarding both these issues is needed before a measuring process can be established.

MDH partnered with the Minnesota Department of Human Services and the Minnesota Council of Health Plans in developing and promoting the universal utilization of the Minnesota Pregnancy Risk Assessment Form (MPRAF) described previously. MCH staff continue to provide technical assistance and consultation to local public health, primary prenatal care providers, hospitals and managed care organizations in addressing system integration of the MPRAF into private and public prenatal clinics. The form assists the primary health provider in identifying and initiating appropriate care, including transfer of pregnant women to a regional facility with capacity for high risk deliveries and neonates.

MCH staff are meeting with two regions, Southcentral and Southwest Public Health Districts, in the state to provide consultation to their efforts to develop and implement an integrated system of prenatal care. Progress is being seen in the cooperative work among health plans, public health and private providers to ensure that medical, social and community based services are made available to all pregnant women. This regional work will serve as a model for the state.

The Minnesota Perinatal Organization (MPO) and the Minnesota March of Dimes (MOD) are examples of two organizations whose purposes focus on healthy pregnancy outcomes. The MCH staff are involved with both groups in program planning for health professionals. The MPO targets all health professions involved in perinatal care in providing educational conferences to improve the health care of pregnant women and newborn infants. In particular MPO as a member of the Great Plains Perinatal

Organization has been instrumental in improving perinatal health care within the six state region through promotion of a regionalized system of perinatal health care services. The MOD focuses on both consumer and professional education.

NP#18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

The percent of infants born to pregnant women receiving prenatal care beginning in the first trimester increased slightly, from 84.1 percent to 84.5 percent. The annual performance objective of 86.9 percent was not met. According to the April 29, 1999 Monthly Vital Statistics Report. (Vol.47, number 18), 31 states had better rates for this measure than Minnesota for non-Hispanic white women (dropping from 29th in 1997). Minnesota's national ranking for African American women was third worst for this measure, and second worst for Hispanic women. Minnesota's efforts to improve early initiation of prenatal care need to be broadly inclusive, but African American and Hispanic women should be specifically targeted with culturally appropriate interventions to reduce their larger disparities.

Title V staff continued to work with public health agencies, area representatives in managed care, and local providers to create a comprehensive, population-based model of prenatal care. Within this model, early identification and initiation of prenatal care is emphasized. Populations within the geographic district who have the lowest rate of initiation of early prenatal care will be targeted to improve those rates.

See also activities previously described for NP #15 (percent of very low birth weight live births) in the Infrastructure Building Services component of this report which addresses disparities, and activities described under NP #18 in the Enabling Services component which includes strategies for early prenatal care.

B. <u>Children and Adolescents</u>

NP # 16 - The rate (per 100,000) of suicide deaths among youths aged 15-19.

The 1998 rate (per 100,000) for suicide deaths among youth, ages 15-19, was 8.9. The rate of suicide deaths to youth, ages 15-19, declined, from 9.8 (1996) to 8.9 (1997 and 1998) per 100,000 youth. The performance objective has been exceeded.

Suicide Prevention Initiative

At the direction of the 1999 Minnesota Legislature (Ch. 245, Article 1, Section 3),the Minnesota Department of Health (MDH) conducted a study of suicide in Minnesota and, in consultation with a large group of stakeholders, developed a statewide suicide prevention plan. The plan includes recommendations from the Commissioner of Health and suggested strategies from an ad hoc advisory group. The report is the first step in implementing a comprehensive suicide plan across multiple organizations in the public and private sectors. The ad hoc advisory group will continue to work with MDH to implement recommendations from the report and develop both policy and funding recommendations for consideration by state agencies, the legislature, and private sector and non-profit partners who have a role in suicide prevention.

Adolescent Health Promotion

The MDH has continued efforts to develop a *"MN Adolescent Health Action Plan"* based on a healthy youth development framework. This project is a collaborative effort with the University of Minnesota and community partners from throughout that state (including adolescents). This project includes development of a framework, evaluation of adolescent health data, development of (recommendations for action), identification of resources to support the action steps, and engagement of key stakeholders in implementing the action steps.

The MN Alliance with Youth is another broad community collaborative in which the MN Department of Health continued to play a critical role. The goal of this "movement" is to help local communities promote healthy children and youth through a healthy youth development model. Activities included training on youth development and community collaboration, technical assistance to support local community efforts and public awareness campaigns to engage people in the project.

GLBT Initiative

The Gay, Lesbian, Bisexual, Transgender (GLBT) Youth Health Initiative as a distinct project ended in 1999. Its purpose was to assess and increase awareness of the health needs of GLBT youth and promote strategies and resources to effectively meet these needs.

The information gained about the health needs of this population as well as the strategies and resources identified have now been integrated into other MDH public health initiatives, such as suicide prevention, reduction of youth risks behaviors including tobacco, school health and children's mental health, and the adolescent health action plan.

Social-emotional Health Promotion

Activities from the past year include completion and evaluation of the University of Colorado's mental health national curriculum for school nurses. 40 school nurses participated in the training held in June/July 1999. It is expected that a national curriculum, including a Minnesota-developed GLBT youth health module, will be released in September 2000.

MCH staff developed three departmental roundtables on social/emotional/well-being of students held in January, February and April 2000. The presenting panels included school administrators, local public health, and youth. Recommendations for continuation of the roundtable series was provided by the approximately 60 staff attending each session.

Staff continue to refine the mental health promotion strategies created and documented in Public Health Goals 2004. A compedium of all mental health technical support requests by local public health agencies across the state will be completed by May 2000, in conjunction with spring regional meetings of local CHS agencies. An intra-agency "mental health interest group" has met three times, with the intent to create a statewide public health framework for mental health. Publications/presentations included a nationally published article in the Journal of School Psychology detailing public health involvement in youth mental health promotion, two articles in statewide publications from the Department of Human Services and Department of Health, and several presentations at children's mental health conferences, and collaborative meetings.

Child and Teen Checkups

In FFY 99 the Title V Child and Teen Checkup staff provided six Child and Teen Checkup training sessions which included instruction on mental health screening and referral. Title V staff also provided consultation to the Department of Human Services to identify mental health screening tools that might be used in the Child and Teen Checkups Program.

NP #12 - The percent of children without health insurance.

The most recent, state-specific analysis of the number of uninsured children 17 and under in Minnesota estimated the uninsured rate at 3.4 percent. The same analysis estimated the proportion of uninsured children in families whose income was 200 percent or less of applicable FPG was 70 percent. Children in these families would be eligible for either MA or MinnesotaCare based on the income eligibility criterion.

Based on the Minnesota Health Access Surveys, the rate of uninsured children 17 and under in

Minnesota is: 1990: 5.3 percent, 1995: 4.3 percent and 1999: 3.4 percent. The Urban Institute estimated the number of uninsured children in the state at 5.0 percent based on a survey conducted in 1999. The three-year moving average from the CPS for children 17 and under who were uninsured was 8.6 percent in 1996-98, 7.1 percent for 1995-97 and 7.2 percent for 1994-96. State and national analysts consider the CPS rates to be artificially high because of methodological reasons.

The Minnesota Department of Human Services (DHS) is the state Title XIX agency and the state agency that administers MinnesotaCare, and the designated Title XXI agency. Working relationships between the Title V program and DHS have been described elsewhere in this application and will be used wherever possible to influence policy decisions in the implementation of the S-CHIP program and the outreach activities of both the MinnesotaCare and Medical Assistance programs. In addition, Title V program staff will collaborate with the state affiliate of the Children's Defense Fund in the CDF campaign (*Covering Kids)* to decrease the number of uninsured children in the state.

NP #13 - Percent of potentially Medicaid eligible children receiving a service paid by the Medicaid program.

Data supplied by the Minnesota Department of Human Services indicates slightly more than 89% of children in Minnesota who were eligible for a Medicaid-paid service, received service during federal fiscal year 1999.

MDH Child and Teen Checkup staff provided outreach promotion activities to increase participation in MA and MinnesotaCare's C&TC program. These activities included discussions of the MA application process and forms during training for PHNs, school nurses, and county C&TC coordinators; outreach training and technical assistance to C&TC coordinators to increase their outreach to public and private C&TC providers; and advising health professionals and families about medical care funding sources during consultant visits with PHN agencies.

MCSHN continued specific activities aimed at increasing MA or Minnesota Care enrollment, including, but not limited to: (1) advising families and professionals who call the 1-800 information and referral line about medical care funding sources and sending out applications for MA or MinnesotaCare as appropriate ; (2) sending letters to families that apply for SSI benefits advising them they will qualify for MA if SSI eligible; and (3) providing inservices around the state to professionals and families regarding the changing requirements and application processes for medical funding options. MCSHN continues to receive a significant number of calls involving MA, MinnesotaCare, TEFRA, and SSI eligibility,

enrollment, and appeals rights.

C. Children with Special Health Care Needs

SP#1 Number of local public health agencies which track children with identified risk factors which may lead to chronic illness/disability.

As of 1999, two reservations and 81 out of 87 counties provided early childhood tracking through the Follow Along Program (FAP). This is up from 47 counties in 1997. The FAP is Minnesota's tracking system for children with identified risk factors which may lead to chronic illness/disability. The performance objective has been exceeded.

Early childhood tracking is defined as "periodic monitoring and assessment of infants and toddlers at risk for health and developmental problems to ensure early identification, help, and services. To accomplish this the Follow Along Program (FAP) has been established by MDH as its early childhood tracking system. As a result of activities initiated in 1998, local public health agencies were provided with funds to initiate or expand FAP in their counties. Linking FAP part C child find activities to core public health functions allowed these communities to identify the natural and supportive fit of this program with other related activities. These funds were for a two year period. In exchange for the funding local agencies agreed to maintain the program at least one year beyond the end of the funds (June 30, 2000).

Technical assistance to local agencies is ongoing. A software program was developed to assist local agencies in the management of the program.

NP #11 - The percent of children with special health care needs in the MCSHN program with a source of insurance for primary and specialty care.

This performance objective was fully achieved reflecting that MCSHN does provide health care coverage for all families who are uninsured and those under-insured. The benefit package for children on the program is quite expansive in its coverage (the only exceptions to coverage are in-home care and some limitation on services).

The number of children with other health care coverage on the MCSHN program is already quite high at 80%. At this point, MCSHN proposes to hold stable the percentage of families who have a source of insurance for primary and specialty care through several efforts. It is hoped that through the state plan for the use of the Title XXI funds (Child Health Insurance Program-CHIP) that MCSHN will be able to assist even more families with obtaining employer-based health care coverage. One of the proposed components of Minnesota's plan for CHIP is to subsidize employer-sponsored insurance for uninsured

children who are ineligible for MinnesotaCare because of their access to employer-sponsored coverage. Other activities of the MCSHN program would be to continue to be a gap filler for families whose commercial health care coverage does not cover the special services required by children with special health needs. That is why it is very important for MCSHN to track the number of children on the program who have insurance as well as those who have no health care coverage. The 80% figure is useful to MCSHN to monitor trends in health care coverage: are more families uninsured, is access to employer based coverage too expensive for families, is the commercial coverage families obtain either privately or through employees offering less of the benefits needed by children with special health needs? These are all questions/concerns to be closely followed.

MCSHN will continue to cover the items that are excluded and/or limited in present benefit sets and to assist in the payment of co-pays and deductibles. MCSHN will also continue its efforts to expand both the Medicaid benefit set package to include more of the services needed by this vulnerable population (such as respite and home and vehicle modifications) and to work with health plans to inform them of the needs of this population for specialized services (such as pediatric specialty care, pediatric equipment and supplies and habilitative services). Additional ongoing work includes expanding the definition of medically necessary care used by health plans to include a pediatric perspective of children's needs for preventive and support services.

NP #14 - The degree to which the state assures family participation in program and policy activities in the MCSHN program.

The consensus among MCSHN staff was that this measure declined from a rating of six in 1998 to a two in 1999. This was related to staffing, financial, and other organizational issues.

Last fiscal year MCSHN hired a parent consultant to explore conceptually the creation of a Family and Community Advisory Committee. The intent was to implement that report, however, because of budget constraints and the lack of a program manager, an internal planning group pared down the consultant's recommendations and considered practical approaches to this implementation. The decision was made that initially only families (not community and providers)would be members. Therefore, it will not be a Family and Community Advisory Committee but a small group of parents will serve as Family Consultants. It is still the intent that professionals and other community members will be added later.

It is agreed that Family Consultants must receive adequate support and training for their parent leadership and advisory role in MCSHN, that MCSHN staff must be assigned to work the Consultants, and that families be adequately reimbursed for their services to MCSHN. The role expectations of the Family

Consultants will be clearly stated and the Family Consultants tasks must be related to areas where program management and staff are willing to allow family involvement. MCSHN has made a commitment of funds for the needed budget and recruitment and training of Family Consultants and other aspects of this plan are in beginning stages, with the objective of having approximately six Family Consultants within the next fiscal year.

It is hoped that this year nothing will forestall plans to have Family Consultants hired, trained, and functioning in an advisory role. However, as delays were experienced by not having a section manager this past year there could be further delays in implementation due to the hiring of a new program manager. The fact that a contract is in place with an external provider to recruit parents as well as plans in place for parents to provide inservice training to MCSHN staff should assure our ability to reach our performance goal.

D. Infrastructure Building Services Affecting All MCH Populations

SP # 7 - The number of counties with a Children's Mental Health Collaborative or a Family Service Collaborative

There are two types of collaboratives in Minnesota: Children's Mental Health Collaboratives (CMHC) and Family Service Collaboratives (FSC). Some counties may have one or the other, some may have both and some have an integrated or combined collaborative. The availability of funding is stimulating growth in the number of participating counties. As of May, 2000, 16 counties had no collaborative, 10 counties had only a CMHC, 27 counties had a combined collaborative and 42 counties had only a FSC. The performance objective was exceeded.

Children's Mental Health Collaboratives

The Children's Mental Health Collaborative is a local integrated service delivery system designed to coordinate an array of services and community supports across multiple systems, so that the health needs of children and their families can be better addressed. The local partnership includes such governmental agencies as corrections, education, public health, social services, vocational services, and a community-appropriate array of non-governmental entities including parents; parent, consumer, community, civic, and religious organizations; private and non profit mental and physical health care providers; culturally specific organizations; and local foundations and businesses.

Public health participation is critical to success of the collaborative development process, which often builds on the foundation of services already in place. Collaboratives utilize public health data and

information, and draw on public health expertise and knowledge of the community in their planning and assessment processes. Analysis of local public health agency plans indicates an increase in public health recognition of children's mental health issues and efforts to collaborate with other available resources to meet these needs. In particular, public health staff promote the prevention, early identification, and early intervention perspectives of the children's mental health systems. Of necessity, much of the collaborative activity is focused on "deep end needs". The overall state and community goal is to move the focus closer to prevention and early identification/intervention approaches. At both the state and community levels, interagency work is building a framework for this change to take place. Title V staff were involved in interagency activities at the state level, in developing the governing and administrative structures, and in collaborative efforts at the local community level. This was accomplished through provision of technical assistance to local MCH and children's mental health collaborative staff.

Family Services Collaboratives (FSC)

Beginning in 1995, grants for implementation of collaboratives were designated for communities that developed measurable goals and a comprehensive plan to improve services for children and families. During 1999, 98 percent of Minnesota's children lived in communities participating in one of 82 FSC's. Twelve original family services collaboratives were in their fifth and final year of funding under the state grant. Staff of the Family Services and Children's Mental Health Collaboratives' public agency partners continue to engage in random moment time studies (Local Collaborative Time Studies) administered by the Minnesota Department of Human Services to generate reimbursement for activities conducted under federal Titles XIX and IV.E. The funds generated under this activity ($30 million in revenue enhancement in 1998) return to a collaborative's integrated fund and must be used by the collaborative to expand prevention and early intervention services for children and families in the community.

Technical support to the local collaboratives is coordinated through interdisciplinary focus teams comprised of state and community level staff. Integrated service delivery systems, governance, information systems and evaluation, and integrated financing are among the broad topic areas addressed by the focus teams. The state public health system is represented by Title V staff working on systems development, children's mental health, children with special health needs, data and information systems, and public health nursing. The professional maternal and child health expertise, both in and outside the Family Health Division, is made available to communities as needs are identified. At the local level, CHB staff are often partners in the collaboratives and find the collaborative goals, objectives, and integrated services delivery venues (one-stop shopping) appropriate to their MCH-related goals, objectives, and

activities. These staff also contribute their MCH health-related expertise to the collaborative technical assistance delivery system in the state.

2.5 PROGRESS ON OUTCOME MEASURES

Please see Form 12 and the narrative which follows.

A. Infant Mortality

The 1998 infant mortality rate for the state of Minnesota was 5.92 deaths per 1000 live resident births. This is the lowest infant mortality rate ever recorded in the state and is identical to the previous year's rate. For the fourth consecutive year, the state's rate was lower than the Healthy People 2000 goal of 7 deaths per 1000. 1998 marks the third year that the state's rate met the Minnesota Public Health year 2000 objective of no more than 6 deaths per 1000 live births.

B. Infant Mortality Ratio: Black/White

The 1997 ratio, of the mortality rates for infants born to African American mothers as compared to infants born to white mothers, was 2.75. There is no directly applicable Healthy People 2000 goal for this ratio, but a separate goal does exist for black infant mortality, at no more than 11 per 1000 live births. In Minnesota the 1997 infant mortality rate for African American births was 14.0. Because there are relatively few African American infant deaths in a single year (ranging from 39 to 56 annually over the past five years) the Minnesota Public Health objective for the year 2000 is stated as reducing the ratio of the five-year average African American to white infant mortality rate. The specific objective calls for a reduction in the five-year running average ratio, from 2.4 (1991 data) to 1.5. Since 1985, the ratio has risen from 1.8 to its current level of 2.75, as measured in the five-year average for 1997. This increase in the ratio is driven by the unequal reductions seen in the infant mortality rates of the two populations. While the mortality rate for infants born to African American mothers has shown a steady decline, the mortality rate has declined even more for infants born to white mothers. The five-year 1978-82 rate for African Americans was 22.6 and dropped to 13.8 for 1992-96; the comparable 1978-82 rate for whites was 10.2 which declined to 5.9 in the 1992-96 time frame.

C. Neonatal Mortality

Neonatal mortality rates rose slowly between 1990 and 1994 and declined between 1995 and 1997. The neonatal mortality rate rose slightly in 1998 to 4.06 from its 1997 level of 3.74. This current rate exceeds the Healthy People 2000 goal of 4.5 per 1000.

D. Postneonatal Mortality

Minnesota's 1998 postneonatal mortality rate is 1.86 per 1000 live resident births. This is the third year the state rate exceeded the Healthy People 2000 goal of 2.5 deaths per 1000.

E. Perinatal Mortality

The 1998 perinatal mortality rate is 6.5 deaths per 1000 live resident births plus fetal deaths. (The numerator is comprised of deaths to infants aged less than seven days, plus fetal deaths occurring at gestation of 20 weeks or less. The denominator is live resident births plus fetal deaths of 20 weeks gestation or more. This measure has shown an average gradual decline over the past seven years, and is now at an all-time low.

F. Child Death

The 1997 child death rate for 1-14 year-olds in Minnesota was 21.4 per 100,000 children of that age range. This exceeds the National age-related mortality objective of 28 per 100,000. Minnesota's current rate is slightly higher than the 1996 rate of 20 per 100,000, which was the lowest ever recorded in the state for this measure.

G. Relationships

The Title V outcome measures are focused on various aspects of infant and child mortality. To the extent that any of these measures improved, it follows that a collective contributory positive impact could have occurred, involving a number of different performance measures. Three of the six Title V outcome measures did show improvement during the reporting period. Post neonatal mortality declined by 0.33 deaths per thousand births, or about 22 actual deaths during a one-year period. Perinatal mortality also declined, by 0.3 deaths per thousand. It appears that most of this improvement can be attributed to a decline in fetal deaths, as neonatal mortality rose during the same time. It is feasible that the modest reduction in smoking rates during pregnancy was in part contributory to the improvements in the outcomes. Pregnancy intendedness may also plausibly be related to these outcomes. The level of insurance coverage of children may also have influenced postneonatal mortality since the state has one of the lowest uninsured rates in the nation.

Targets were not met for four of the outcome measures: infant mortality and neonatal mortality rates, ratio of black to white infant mortality rate and the child death rate.

Infant mortality remained at the same rate as for the previous year, and neonatal mortality showed a slight increase. These measures could have been influenced by maternal smoking levels, pregnancy intendedness as influenced by family planning programs, the level of referral of women at risk for preterm delivery to receive care at facilities with level II and III nurseries, and the level at which women receive early and adequate prenatal care. The level of very low birth weight live births showed a small decline during the reporting period.

Factors outside the control of the Title V programs which may have affected these outcome indicators include changes in the sociodemographic composition of the population. The metropolitan area of Minneapolis and St. Paul continues to be one of the fastest growing urban areas of the Mid West. Minority populations continue to grow and much faster than the white population and growth of concentrated poverty within the core cities continues as well.

The black-to-white ratio of infant mortality may, in part, be related to the above-mentioned sociodemographic changes. However, opportunities to improve access to care, and to develop more culturally appropriate programs and services, must be acknowledged. Most of the African American population within the state are served by three community-level departments of health. Closer coordination with these departments regarding prevention of African American infant mortality has become a greater commitment. One of the state's discretionary performance measures is focused on ensuring that the MCH plans developed by local public health agencies include objectives and methods to eliminate disparity in health status of minority populations.

Finally, the rise in child deaths during the current reporting period appears to be largely attributable to the rise in deaths of children due to motor vehicle crashes. During this period there was a marked rise in vehicle speed and also a rise in the percentage of crashes involving alcohol.

III. REQUIREMENTS FOR APPLICATION

3.1 NEEDS ASSESSMENT OF THE MATERNAL AND CHILD HEALTH POPULATION

3.1.1 NEEDS ASSESSMENT PROCESS

A. Vision and Work Plan for the MCH Needs Assessment 2000

MCH and MCSHN staff developed a vision and work plan for completing the MCH Needs Assessment 2000 in collaboration with members of the MCH Needs Assessment 2000 Work Group (Appendix K.) and MCH Advisory Task Force. Specific activities included: 1. developing a vision for conducting a state-of-the-art assessment of the health status and health needs of women and children living

in Minnesota, 2. developing a plan for conducting the *MCH Needs Assessment 2000*, 3. selecting key health indicators for possible inclusion in the *MCH Needs Assessment 2000* document after conducting a review of currently available health indicators for women and children and identifying possible gaps that may exist, 4. gathering, interpreting, and displaying health indicators data that may be included in the *MCH Needs Assessment 2000*, 5. conducting a public input process to ensure citizen participation in identifying the health needs of women and children living in Minnesota, and 6. writing the *MCH Needs Assessment 2000*. Significant resources to support these activities were provided by the State Systems Development Initiative grant awarded by the federal Maternal and Child Health Bureau.

The MCH Needs Assessment 2000 Work Group met on a monthly basis from March through December, 1999 and in March, 2000. During this time period, the Work Group: 1. developed a vision for conducting the needs assessment (Appendix L. MCH Needs Assessment 2000: Vision Statement), 2. approved the work plan (Appendix M. Proposed MCH Needs Assessment Work Plan), reviewed available health status indicators and identified those with highest priority for inclusion in the needs assessment, 3. recommended that focus groups be conducted to provide consumer input into the needs assessment process, 4. recommended that Community Health Service Agency needs assessment results be incorporated into the statewide needs assessment, 5. reviewed and approved the draft outline of the needs assessment, 6. reviewed and made editorial comments on draft figures and text for the needs assessment, and 7. participated in the April 14, 2000 MCH Advisory Task Force meeting in a session focused on piloting a tool for identifying priority needs of the MCH population in Minnesota.

B. Public input into the priority needs of the MCH population.

Public input was garnered in three distinct ways. First, a compendium of all health and well being indicators that are collected and reported by the major state agencies and the Children's Defense Fund was constructed. These indicators were summarized in a *MCH Indicators Menu* (Appendix N. MCH Needs Assessment 2000: Indicators Menu). Each of the indicators included in the menu had been previously subjected to public input for inclusion in reports by the state agencies and the Children's Defense Fund. Second, MCH staff reviewed the Community Health Service Agencies needs assessment that were conducted as part of their year 2000 biannual plans. MCH needs identified through this process were added to the already extensive list of needs reflected in the *MCH Indicators Menu*. Third, upon the recommendation of the MCH Needs Assessment 2000 Work Group, a contract was developed with the Wilder Research Center for the specific purpose of gathering input from consumer groups. The targeted groups for the focus groups included: MCSHN/Metro, MCSHN/Greater Minnesota, Working Poor/Metro,

Working Poor/Greater Minnesota, African American/Urban, and Native American/Greater Minnesota. The contract instructed the Wilder Research Center staff to explore the general theme of family support which was to include topics related to: (a) community resources used/needed, (b) family planning resources used/needed, (c) mental health resources used/needed, and (d) dental health resources used/needed. The final report of the Wilder Research Center included a wealth of information relevant to MCH needs as viewed by consumers (Appendix O. Keeping families healthy).

Additional focus group input was gathered from the Urban Coalition, the Minnesota Organization for Adolescent Pregnancy, Prevention, and Parenting (MOAPP), and the Minnesota Department of Health, Adolescent Health Program (Appendix P. Conversations with Minnesota Teens about their Health and Well-being). Findings and recommendations of these consumer-based focus groups were included in the needs assessment and in the *MCH/MCSHN Priority Needs Menu.*

C. Priority Needs for Minnesota MCH Populations

The priority needs were identified through a process that culminated in the statewide mailing of the *MCH/MCSHN Priority Needs Menu* (Appendix Q. MCH/MCSHN Priorities Needs Menu) to members of the Maternal and Child Health Advisory Task Force and MCH Needs Assessment 2000 Work Group, local public health agencies, and public health nursing directors. The menu was developed by MCH and MCSHN staff based on the recommendations of the Work Group and Advisory Task Force. Items included in the menu were derived from the *MCH Indicators Menu* results and the findings and recommendations of focus groups conducted by the Wilder Research Center, the Minnesota Department of Health, the Urban Coalition, and MOAPP. See Appendix R. Results of the MCH Block 2000 Priorities Menu Survey.

3.1.2 NEEDS ASSESSMENT CONTENT

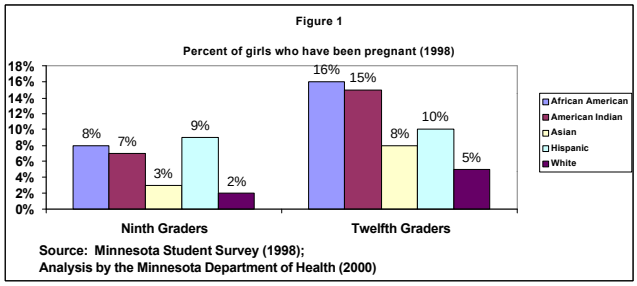
3.1.2.1 OVERVIEW OF THE MATERNAL AND CHILD HEALTH POPULATION HEALTH STATUS

A. Mothers, Infants, Children and Adolescents

On an ongoing basis the MCH/MCSHN programs are engaged in assessment activities. For background information please refer to 1.4 Overview of the State for information concerning demographics and the health care environment. A description of specific topics follows.

Teen pregnancy. Teen pregnancy rates in Minnesota have declined across the last two decades, reflecting national trends. Nonetheless, teen pregnancy remains at unacceptably high levels when considering the long-term consequences of children bearing children. In addition, much lower teen pregnancy rates have occurred among developed nations in Europe, suggesting that decreases in teen pregnancy rates among Minnesotans is feasible.

Teen pregnancy rates among African American, American Indian, and Hispanic populations residing in Minnesota are higher than are found among White and Asian-American teens (Fig 1). The discrepancy in teen pregnancy rates among the racial/ethnic groups living in Minnesota, and the fact that European nations have achieved lower teen pregnancy rates than has the USA suggest that there is much room for improvement in reducing the teen pregnancy rates among Minnesota youth, aged 12-19 years.



According to the Urban Coalition (1998), many high school girls reported having been pregnant at least once. In 1997, total pregnancies among youth aged 12-14, 15-17, and 18-19 were estimated at 165; 2,850; and 5,194 in 1997 (Table 1).

Table 1

Pregnancies, live births and abortions among adolescents aged 12-19 (1997)

	Age Range		
	12-14	15-17	18-19
Total Pregnancies	165	2,850	5,194
Pregnancy Rate per 1000	0.9	26.4	78.1
Live Births	93	1,918	3,664
Birth Rate per 1000	0.5	17.8	55.1
% of Births to Unmarried Women	97.8%	94.0%	82.1%
% Aborted Pregnancies	43.6%	32.3%	29.1%

Source: Minnesota Department of Health (1998)

Teen Birth Rate. In 1997, the birth rates among girls aged 12-14, 15-17, and 18-19 years was 0.5/1000, 17.8/1000, and 55.1/1000, respectively (Table 1). Live births to teens under 18 years comprised 2.9, 3.1, and 3.1 percent of all births in 1994, 1996, and 1997, respectively (*Children's Report Card,* Minnesota Planning). Bearing a child during the teen years is associated with higher rates of dependence on public assistance, higher risk for prenatal and birth complications, and poorer outcomes among infants. Young mothers are also more likely to be

unmarried and to function as single parents. With pressures to obtain employment that are occasioned by welfare reform, these single parents struggle to meet multiple demands. Children of teen parents tend to have lower educational expectations, lower levels of academic achievement, and more behavioral disorders than do children born to more mature parents.

Birth rates among African American, American Indian, Hispanic, and Asian American teens, aged 15-19, were higher than was observed among Whites (Fig 2). African American youth, aged 15-19, for example, were five times more likely than Whites to give birth. These data suggest that racial disparities in both pregnancy and birth rates among adolescents living in Minnesota are key areas of concern for future efforts to reduce teen pregnancies and births.

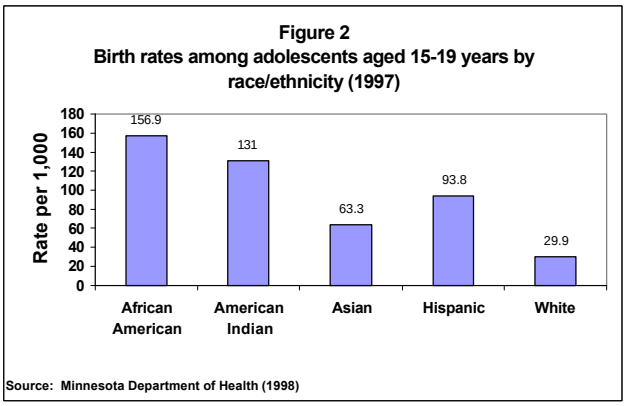
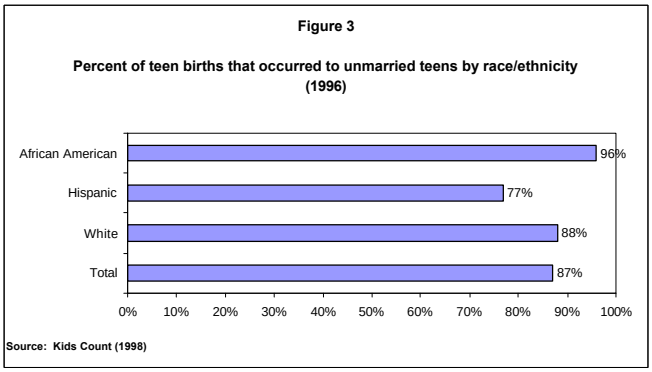


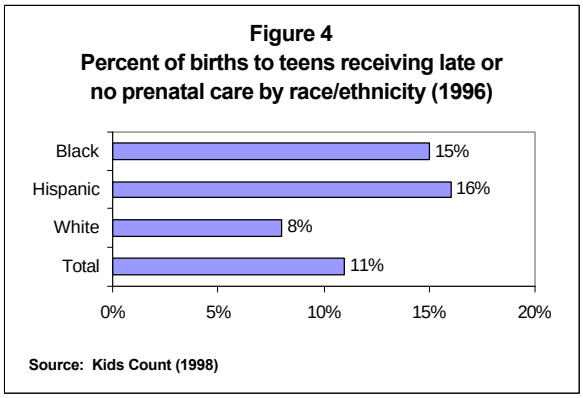
Table 2

	USA	Minnesota	National Ranking
Percent of teen births that occurred to unmarried teens, 1996	76	87	40

Source: Kids Count (1998)

Births to unmarried girls comprise a significant proportion of the total births to those aged 12-19 years. Ninety-eight percent of births to mothers aged 12-14, 94% of births to mothers aged 15-17, and 82% of births to mothers aged 18-19 years occurred among unmarried girls (Table 1). Teen mothers in Minnesota were more likely to be unmarried than teen mothers nationwide in 1996 (Table 2), according to the Annie E. Casey Foundation (1998). And, Non-Hispanic African Americans and Non-Hispanic Whites were more likely than Hispanics of any race to give birth outside the institution of marriage (Fig 3).





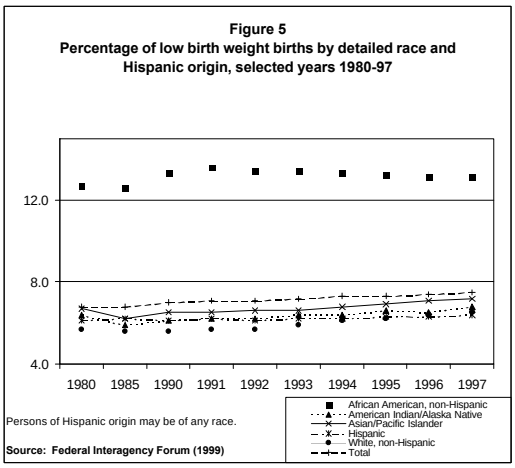
According to the Annie E. Casey Foundation (1998) a significant proportion of teens who give birth received late or no prenatal care (Fig. 4). In 1996, for example, 16% of Hispanic teens, 15% of Non-Hispanic African Americans, and 8% of Non-Hispanic Whites living in Minnesota received late or no prenatal care. Twenty-five percent of teens giving birth reported smoking during pregnancy (Annie E. Casey Foundation, *Kids Count*, 1998).

Table 3

	USA	Minnesota	National Ranking
Percent of teen births that are repeat births, 1996	22	19	14

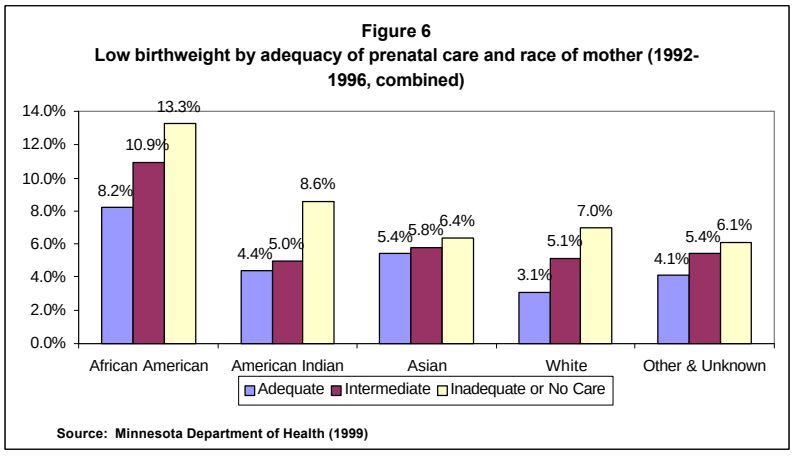
Source: Kids Count (1998)

Nationally, 22 percent of teen births were repeat births in 1996 (Table 3). Minnesota ranked 14th among the states with a repeat teen birth rate of 19%.

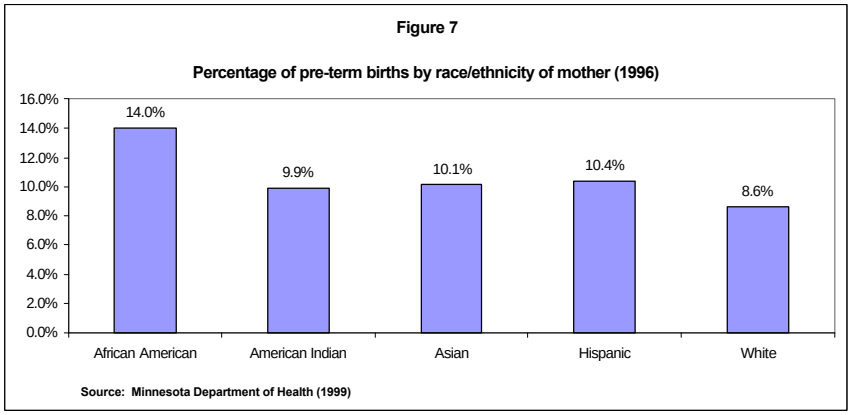


Among Minnesotans, 44%, 32%, and 29% of pregnancies among girls aged 12-14, 15-17, and 18-19 years, respectively, were terminated in abortion in 1997 (Table 1). These rates reflect, in part, the degree to which the pregnancies were unplanned or unwanted and the difficulties anticipated when children and teens give birth. Reducing pregnancy, birth, and abortion rates among Minnesota's young women remains a significant challenge and worthwhile goal.

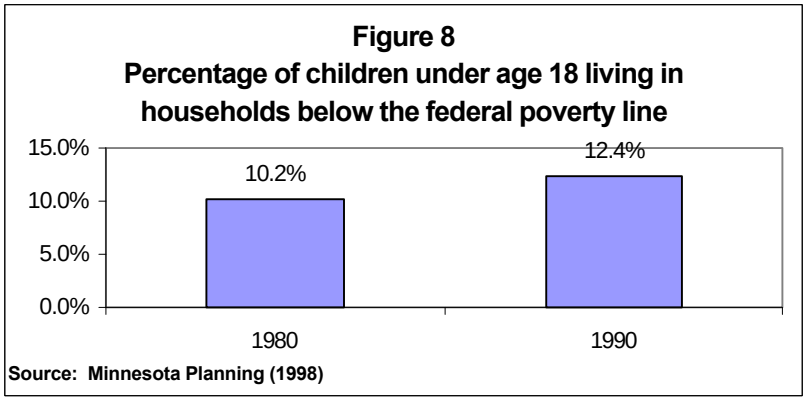
Low Birth Weight. Defined as a live birth of less than 2,500 grams (or 5 pounds, 8 ounces), low birth weight contributes to infant mortality, as well as long-term illness and disability. Nationally, 7.5% of all births met criteria for low birth weight in 1997. Approximately 12-13% of Black, non-Hispanic infants were born having low birth weight, while 5-7% of Hispanic; White, non-Hispanic; American Indian; and Asian American births were classified as low birth weight (Fig 5).



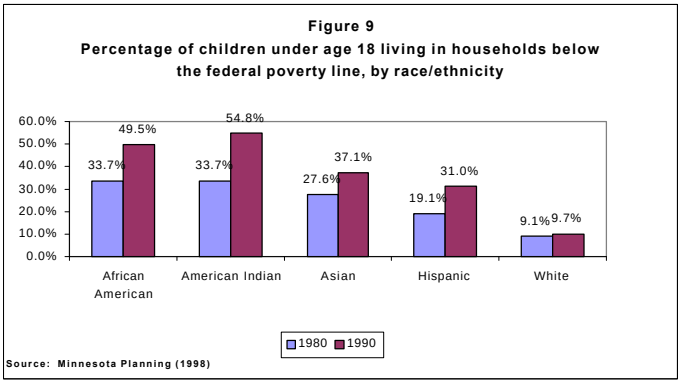
In Minnesota, both low birth weight and pre-term deliveries

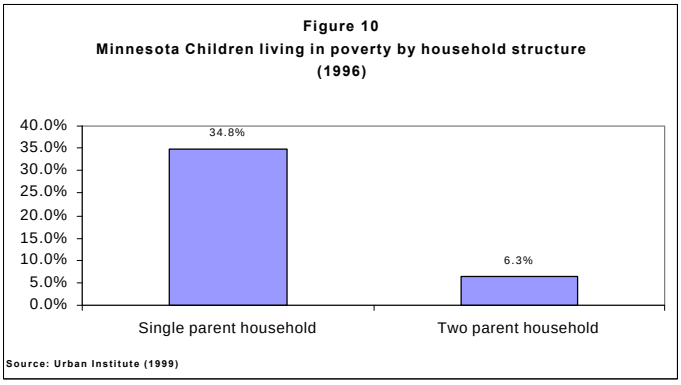


were more common among African American, than American Indian, Asian, White, and Hispanic, women (Figs 6-7). According to the Minnesota Department of Health (1999), African American, American Indian and Asian American women also less likely than White women to receive adequate prenatal care. Thus, low birth weight among Minnesotans reflected national statistics which show disparity across racial/ethnic groups. The Minnesota data further suggest that inadequate prenatal care may be an important predictor of low birth weight. Interventions to assure adequate preconception and prenatal care among all segments of the child-bearing population are warranted. This includes taking steps to improve health insurance coverage among all women of child bearing age.



Poverty. Childhood poverty is associated with poor health, poor academic performance, and less than adequate access to the necessities of life such as food, clothing, and a safe shelter. Children who grow up in poverty are also more likely to become teen parents and to be victims of crime and violence than are children who grow up in non-impoverished circumstances. Minority and immigrant children are more likely than White and non-immigrant children to experience childhood poverty. Many of the health disparities associated with race and ethnicity may be attributable to growing up in poverty. Poverty is, therefore, a key indicator of childhood health and well being worldwide. In Minnesota, childhood poverty in the general population was estimated at 10.2% in 1980 and 12.4% in 1990 (Fig 8). A 1996 survey conducted by the Urban Institute revealed a similar estimate of child poverty in Minnesota at



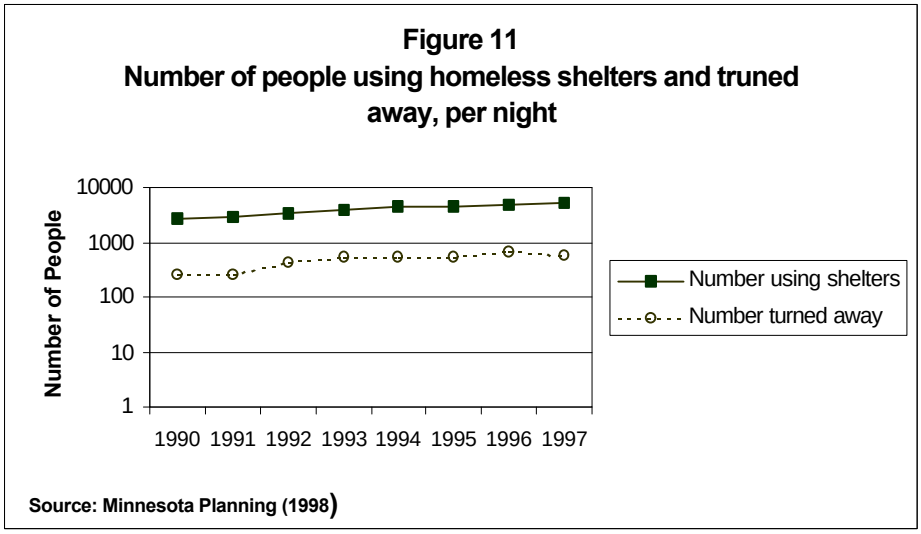


12.5%. Somewhat differing estimates of child poverty were reported by the Annie E. Casey Foundation (KIDS Count, 1998), which estimated child poverty in Minnesota at 14% in 1985 and 15% in 1995. For comparison purposes, national estimates of child poverty were 17.9% in 1980 and 19.9% in 1990 (Federal Interagency Forum on Child and Family Statistics, 1999). By all estimations, child poverty increased from 1980 to the present.

Reflecting national trends, poverty among Minnesota children is more common among minorities (Fig 9) and among children who live in single versus two-parent households (Fig 10).

The increased proportion of racial and ethnic minority children living in Minnesota and the increased likelihood of children being raised in single-parent households which are anticipated over the first decade of the new millennium suggest that these two factors will continue to be important in determining the health and well being of children living in the state.

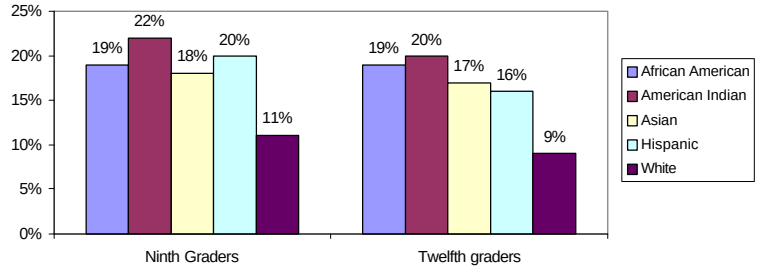
Homelessness, Affordable Housing, and Food Security. Adequate access to safe shelter is a prerequisite for child health and well being. Thus, it is shocking that about one half of all people using homeless shelters are children. In Minnesota, use of homeless shelters doubled from 1990-1997, as did the number of people



turned away each night (Fig 11). These findings suggest a significant deterioration in access to safe shelter for those children in greatest need.

Among parents living in Minnesota, 13.1% of all parents and 28.2% of parents living under the federal poverty level reported problems with paying their mortgages, rent, or utility bills (Urban Institute, 1999). Thus, obtaining affordable housing is a significant challenge to many parents living in Minnesota who wish to provide a safe and nurturing environment for children. Likewise, obtaining affordable food concerned 24.4% of all families and 50.1% of families living under the federal poverty level (Urban Institute, 1999).

Figure 12
Percent of students who were hit hard or often by an adult in household (1998)

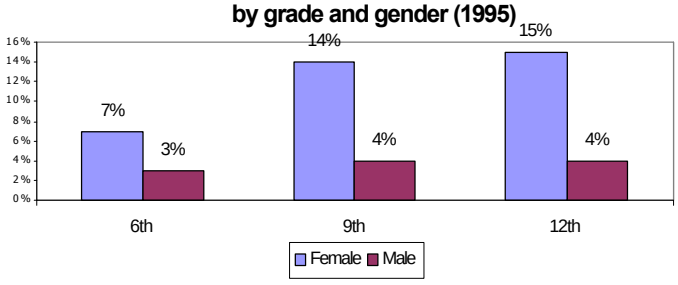


Source: Minnesota Student Survey (1998); Analysis by Minnesota Department of Health (2000)

Child Abuse and Neglect. Physical abuse, sexual abuse, and neglect can scar a child for life and may result in physical injury, behavioral problems, school difficulties, or future criminal activity. Among Minnesota's children, the rate of substantiated abuse and neglect cases has remained relatively constant from 1990 to 1996 (Minnesota Planning, 1998) at about 8-9 per thousand. However, when surveyed, Minnesota students reported much high rates of physical abuse, ranging from 11-22% among 9th graders and 9-20% among 12th graders (Fig 12). Minority students were more likely than Whites to report being hit hard or often by an adult in their household.

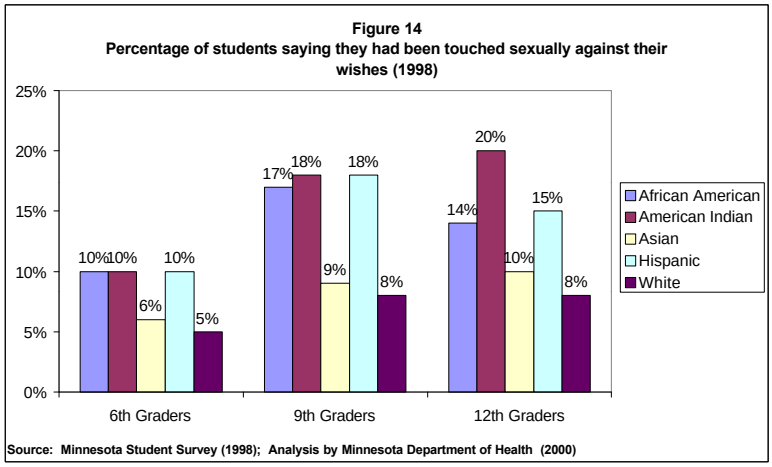
The percentage of students who reported sexual abuse ranged from 8.6-9.7% among 9th graders and from 8.4-11.7% among 12th graders (Minnesota Planning, 1998). Female students were much more likely than males to report having been touched sexually against their wishes (Fig 13).

Figure 13
Percentage of students who have been sexually abused, by grade and gender (1995)



Source: Minnesota Student Survey (1995); Analysis by Minnesota Department of Health (1999)

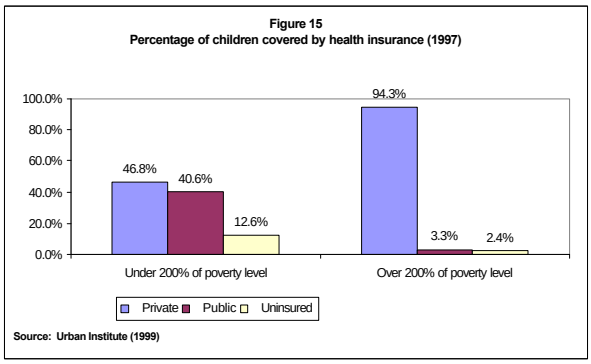
African American, American Indian, and Hispanic students were more likely than Asian or White students to report having been touched sexually against their wishes (Fig 14).



Access to Health Services.

Not having health care insurance represents a major barrier to receiving needed health care services among children. Estimates of uninsured children vary by source. In the state-specific *Minnesota Health Access Survey*, 1999, the estimate of children 17 and under who were uninsured was 3.4 %. In its 1999 report, the Urban Institute estimated 5 % of Minnesota children were uninsured during 1997.

Nationally, 11.9% of children were uninsured in 1997 (Urban Institute, 1999). Thus, Minnesota compared favorably to the nation as a whole when examining the health care coverage of its children. However, among those living in poverty in Minnesota, health care coverage was lower (87.4% versus 97.6%) and the proportion of children covered by public health insurance was higher (40.6% versus 3.3%) than was true for those who were living in less impoverished circumstances (Fig. 15).

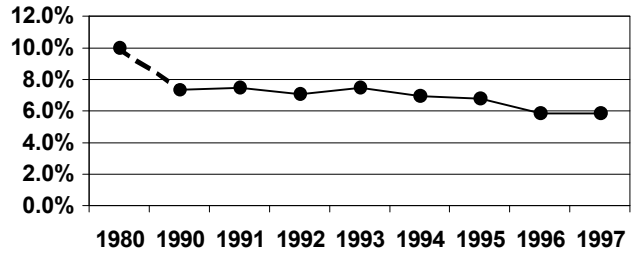


Parental confidence in obtaining needed health care for their children represents another way to examine access to health services. In Minnesota, 3.7% of all parents lacked confidence in getting medical care for their children in 1997 (Urban Institute, 1999). Those living in poverty express less confidence in obtaining needed health care for their children than those who were not (6.8% versus 2.4%). Children lacking a usual source of health care may be less likely than others to receive needed services. In 1997, 2.2% of children lacked a usual source of care (Urban Institute, 1999). Of those, children living in poverty were more likely than those not living in poverty to lack a usual source

of care (3.2% versus 1.8%).

Access to needed health services is also affected by the number and proportion of health service delivery providers and by physical proximity to providers. In rural Minnesota, both the number of specialty providers and the physical distance to providers of all types may represent a barrier to receiving needed health care.

Figure 16
Infant mortality rate per 1,000 live births

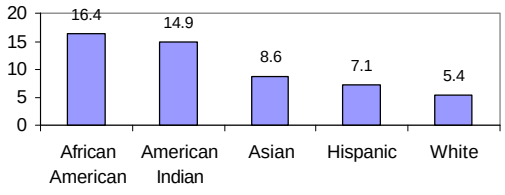


Source: Minnesota Department of Health (1998)

Infant Mortality. Acknowledged to be a premier health indicator worldwide, infant mortality declined in Minnesota from 10.0 to 5.9 deaths per 1,000 live births from 1980 to 1996 (Fig. 16). The leading causes of infant mortality are congenital anomalies, sudden infant death syndrome (SIDS), perinatal conditions, and short gestation/low birth weight, among others. Medical advances in caring for very premature infants have improved survival rates. In 1996, the infant mortality rate of 5.9/1000 was the lowest ever recorded in the state. In that year, the state met the *Minnesota Public Health 2000* objective of no more than 6 deaths per 1,000 births and the nation's *Healthy People 2000* goal of no more that 7 deaths per 1,000 (Minnesota Department of Health, 1999). Neonatal deaths and fetal deaths have also declined in Minnesota.

In 1996, the national infant mortality rate was 7.2/1,000. Thus, Minnesota compared favorably to the nation in its overall infant mortality rate. However, African American and American Indian infants died at much higher rates than was true of Asian, Hispanic, and White infants (Fig 17). Reducing infant mortality among minority populations living in Minnesota is a continued challenge.

Figure 17
Infant mortality rate per 1,000 live births by race/ethnicity (1995-1997)



Source: Minnesota Department of Health (1998)

Recent evidence suggests that sudden infant death syndrome (SIDS) occurs at alarming rates in Minnesota day care settings, accounting for 40% of all SIDS deaths in the state (Moon et al, 1999). Babies are at highest risk for SIDS at 2-4 months, which is often when they begin to go to daycare. Interventions to reduce SIDS in day care and other settings are needed.

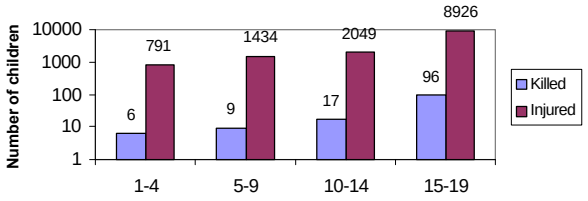
Table 4
10 Leading Causes of Death by Condition and Age Group
Minnesota 1993 - 1997

Condition	<1	1-4	5-9	10-14	15-24	Total
1. Unintentional Injury	63	155	121	151	1027	1517
2. Congenital Anomalies	574	66	17	19	37	713
3. Suicide				39	393	432
4. SIDS	349					349
5. Homicide		23	9	18	227	277
6. Cancer		41	38	37	112	228
7. Other Perinatal Conditions	198					198
8. Maternal Complications	179					179
9. Short Gest./Low Birthwt.	175					175
10. Heart Disease	39	14	9	13	64	139
11. Placental Complications	110					110
12. Respiratory Distress	64					64
13. Perinatal Infections	58					58
14. Pneumonia & Influenza		16	5	6	12	39
15. Stroke		4	2	6	20	32
16. Chronic Obstr. Pulmonary Dis				5	14	19
17. AIDS/HIV		3	1		12	16
18. Septicemia		4	3	1		8
19. Perinatal Conditions		4				4
20. Benign Neoplasms			1			1
Total	1809	330	206	295	1918	4558

Source: Minnesota Department of Health (2000)

Child Mortality. Loss of a child is arguably the most difficult experience a parent must endure. A caring society acknowledges this loss and takes steps to prevent further losses. From 1985 to 1995, child mortality in Minnesota decreased from 30/100,000 to 23/100,000 (Minnesota Department of Health). Among children and young adults, ages 1-24, unintentional injuries were the leading cause of death (Table 4). Many of these deaths were attributable to motor vehicle crashes (Fig 18). Of those killed or injured in motor vehicle crashes, a significant proportion were not using seat belts or child restraints. Driver fatigue, alcohol, and drug use contribute to traffic fatalities among children. Among drivers aged 15-19 years who were killed in motor vehicle crashes, an estimated 24-41% had been drinking alcohol (Minnesota Department of Public Safety, 1999).

Figure 18
Minnesota children killed or injured in motor vehicle crashes, by age in years (1996)



Source: Minnesota Department of Public Safety (1997)

Suicide and homicide lead the list of violent causes of death among children (Table 5). Among 9th and 12th grade students living in Minnesota, a disturbing 9.9 to 14.0% reported having attempted suicide (Minnesota Planning, 1998). Efforts to improve the mental health of youth, and thus prevent suicide deaths are clearly warranted (see *Mental Health of Children and Parents*, below.) Childhood deaths from chronic diseases such as cancer, heart disease, diabetes, and asthma continue to cause concern, as do deaths from infectious diseases including pneumonia/influenza

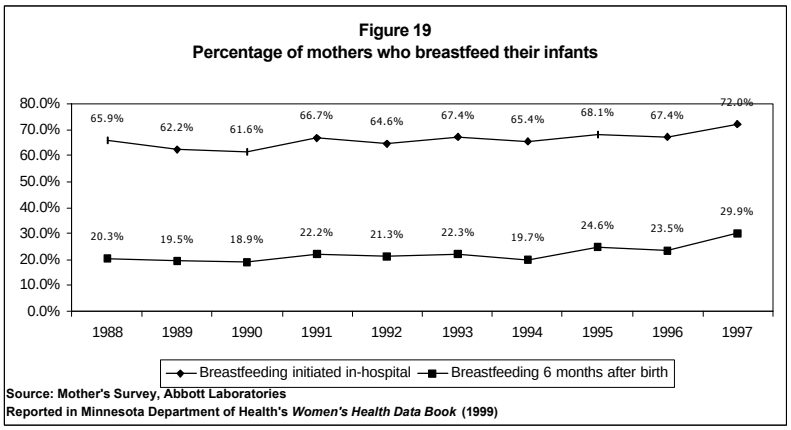
Table 5
Minnesota children:
Suicide and homicide deaths, 1993-97

	Suicide	Homicide
Children aged 1- 4 years	0	23
Children aged 5- 9 years	0	9
Children aged 10-14 years	39	18
Children aged 15-24 years	393	227
Total	**432**	**277**

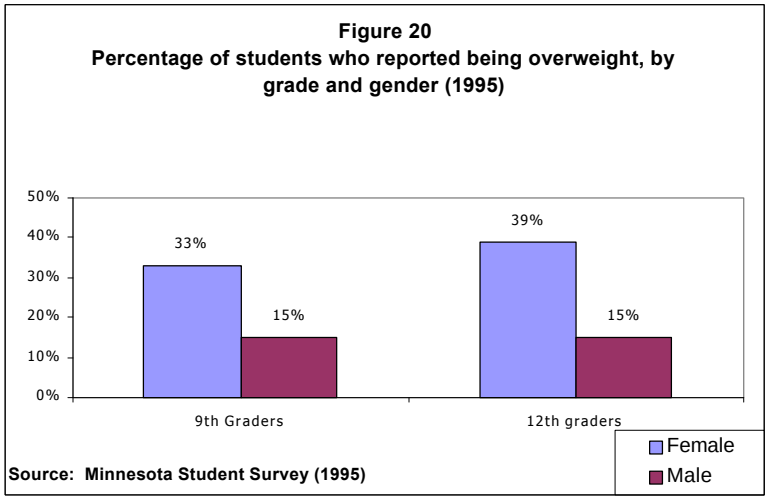
Source: Minnesota Department of Health (2000)

and HIV/AIDS (Table 4).

Infant, Child, and Youth Nutrition. Though little is known about the dietary intake of infants, children, and youth living in Minnesota, national data provide ample information suggesting that breast feeding is done too infrequently, food security is a problem for low income children, and unhealthy, lifelong, dietary habits are established in many children and youth. Childhood obesity is currently at an all-time high in the USA.



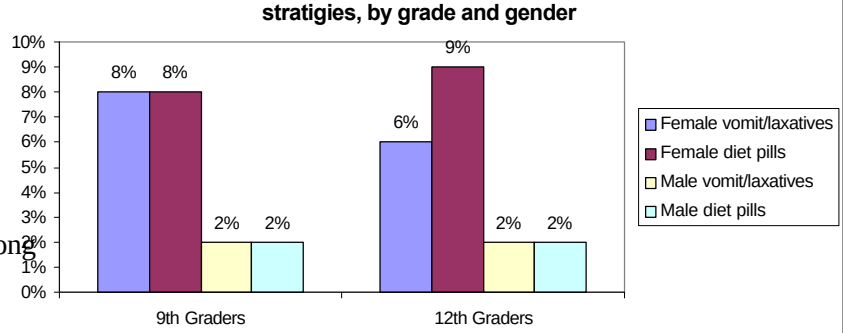
Breast feeding initiation and duration provide some insight into infant nutritional status. Among Minnesota mothers surveyed from 1988 to 1997 by Abbott Laboratories, breast feeding initiation increased from 66 to 72%, while breast feeding for 6-months duration increased from 20 to 30% (Fig 19). As noted previously in this report, obtaining affordable food concerned 24.4% of all Minnesota families and 50.1% of Minnesota families living under the federal poverty level (Urban Institute, 1999). Thus, access to affordable food remains a concern for some Minnesotans. Conversely, over availability of high fat, low nutrient food choices for many children and youth have led to a new epidemic of childhood obesity nationwide. Though Minnesota-specific data are unavailable at this time, the presumption of increased childhood obesity remains a concern due to evidence that obesity tracks over time and that in adults, obesity has major health consequences, including an increased risk for heart disease, diabetes, and some forms of cancer. (The importance of regular physical exercise and related data are provided later.)



According to the Minnesota Student Survey, both males and females reported being overweight (Fig 20). These weight concerns were accompanied by a variety of

unhealthy weight control practices including vomiting or laxative use and the taking of diet pills (Fig 21). Though representing the tip of the iceberg in estimating the prevalence of eating disorders among Minnesotans, 157 females and 13 males were admitted to Minnesota hospitals for treatment of anorexia and 59 females were admitted for treatment of bulimia in 1996.

Figure 21
Percentage of students who reported unhealthy weight control stratigies, by grade and gender



Source: Minnesota Student Survey (1995)
Reported by MN Department of Health's *Women's Health Data Book* (1999)

Child and Youth School Readiness and Academic Performance

Health and education are inextricably linked. Numerous studies have shown that health varies as a function of education, with those completing high school and college enjoying better health than those with less education. However, health difficulties in early childhood can impair a child's ability to benefit from educational opportunities.

School readiness implies that children are physically, emotionally, and socially ready to benefit from educational experiences at an early age. From a health standpoint, it is recommended that children be up-to-date on immunizations and that they be screened for possible social, motor, cognitive, language, and communications skills prior to beginning kindergarten. Minnesota is the only state in the nation to provide universal screening program for preschoolers, aged 3-4 years. In 1996, 88.8% of children screened were found to be within normal limits, while 11.2% were referred for further assessment. Of these, 4.3% were placed in special education to best meet their needs. In 1997, 86.6% of children screened were within normal limits, and slightly more children were referred for further assessment (13.4%). But, the percentage of children placed in special education remained about the same at 4.5% (Minnesota Planning, 1998).

On-time immunization is an important health factor that contributes to school readiness. Immunization provides protection against major childhood infectious diseases including hepatitis, diphtheria, tetanus, polio, measles, mumps, and rubella. From 1988 to 1996, on-time immunizations increased from 57.4 to 68.4% among Minnesota children, aged two years (Minnesota Planning, 1998). The National Immunization Survey estimated childhood immunization in Minnesota to be substantially higher, at 82.2% (Centers for Disease Control 1999). Likewise, the Annie E. Casey Foundation reported

statewide immunization rates for two-year children to be 85% (*Kids Count*, 1998). Notably, all of these estimates of the immunizations rate achieved in Minnesota fall short of the year 2000 goal of 90%. Nationally, children living in poverty were less likely to receive up-to-date immunizations than children who were not living in poverty (Federal Interagency Forum, 1999).

Additional information on well child care is limited. As part of its regulatory oversight of Health Maintenance Organizations (HMOs), Minnesota collects data on several clinical care measures developed by the National Committee for Quality Assurance (NCQA) through its Healthplan Employer Data and Information Set (HEDIS) activity. In 1999, starting with 1998 data the Minnesota Department of Health began collecting data on HMO well-child care (birth through 15 months of age) and 3 through 6 years of age as well as adolescent well-visit care. Data were collected for these three age cohorts by commercial plan, Medicaid managed care plan, and MinnesotaCare. Results from data on clinical care measures are usually not published to allow health plans to resolve methodological errors. Nevertheless, the first year data strongly suggest lost opportunities for appropriate utilization of child and adolescent preventive health care services.

Reading and telling stories to young children is another indicator of school readiness. In Minnesota, 13.1% of parents reported reading or telling stories to their children aged 1-5 years fewer than three days per week. A larger percentage of those living in poverty, compared to those not living in poverty (17.5% versus 10.9%) reported reading or telling stories to their children fewer than three days per week (Urban Institute, 1999).

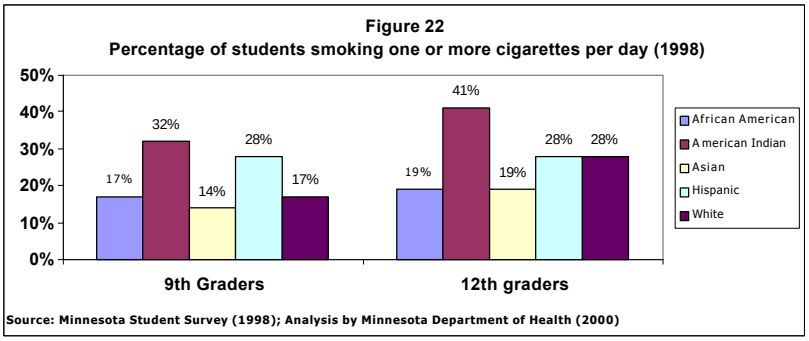
School engagement is an indicator of current and future academic success. In Minnesota, 37.9% of children 6-11 years of age and 30.7% of children 12-17 years of age were found to be highly engaged in school (Urban Institute, 1999). Of all children aged 6-17 years, those living in poverty were less likely to be highly engaged in school than those not living in poverty (34.6% versus 41.5%). School engagement data among Minnesota's children were similar to that which was obtained for the nation as a whole.

Mental Health of Children and Parents. Among Minnesotans, 6.8% of children aged 6-11 years and 9.2% of children aged 12-17 years exhibited high levels of behavioral and emotional problems according to their parents (Urban Institute, 1999). Children living in poverty, however, exhibited more symptoms of poor mental health than was true of those not living in poverty (10.2% versus 5.3% for children aged 6-11 years; 12.6% versus 8.0% for children aged 12-17 years).

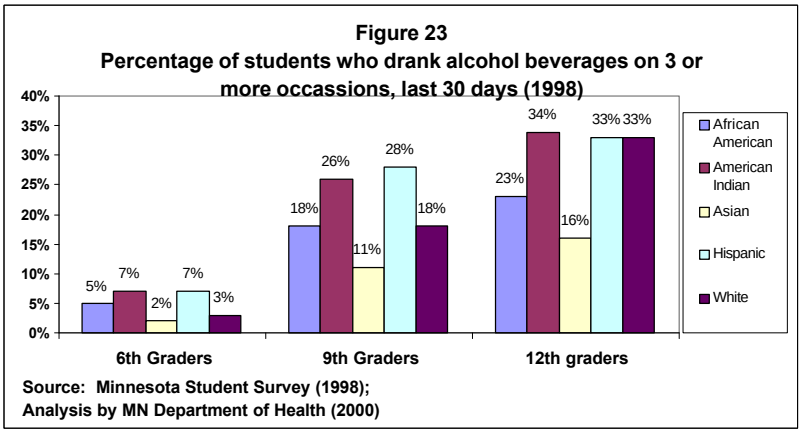
The mental health of parents can have a substantial impact on the well being of their children. Thus, it is of concern that in 1997, 14% of Minnesota's children lived with a parent whose symptoms

suggested poor mental health (Urban Institute, 1999). The percentage of parents exhibiting symptoms of poor mental health was 23.5% for children living in poverty, compared to 9.6% for those who were not living in poverty.

Improving access to mental health services and reducing the stigma of seeking mental health care are expressed needs of children, youth, and their parents living in Minnesota, (Wilder Research Center, 2000; Minnesota Department of Health, 1999). The likely benefits of efforts to improve mental health among MCH populations in Minnesota would include: (a) reduced suicide deaths and attempts among youth, (b) decreased child abuse and neglect, and (c) improved school performance among children. Addressing the mental health needs of women, children, and youth are clearly warranted.

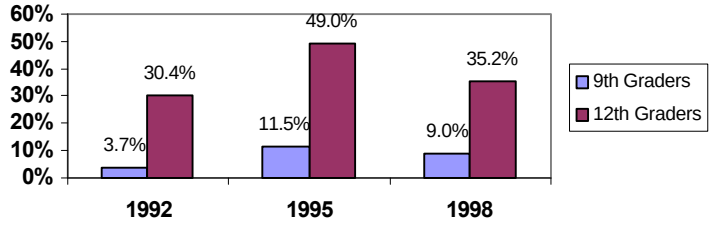


Youth Risk and Protective Behaviors. Smoking is the number one preventable cause of disease in the United States. Thus, youth tobacco use is of major concern and has long-term consequences for the health of Minnesotans. In 1998, 20.5% of 9th grade and 34.0% of 12th grade students reported weekly or daily use of cigarettes, chewing tobacco, or snuff according to the *Children's Report Card* (Minnesota Planning, 1999). American Indian, Hispanic, and White students were more likely to report daily smoking than were African American or Asian students (Fig 22). Nationally, 22% of 12th grade students reported daily smoking. White students, were more likely than Hispanic or African American students to report daily smoking (Federal Interagency Forum, 1999). In 1998, alcohol use among Minnesota students, defined as having consumed alcoholic beverages in the last year, topped 55.6% among 9th grade students and 71.5% among 12th graders in 1998 (Minnesota Planning, 1999). African American and Asian students were less likely than American Indian, Hispanic, or White



students to report drinking alcoholic beverages (Fig 23). A disturbing finding of the Minnesota Student Survey is that a significant proportion of students reported that they drove a motor vehicle in the past year after using alcohol or others drugs (Fig 24).

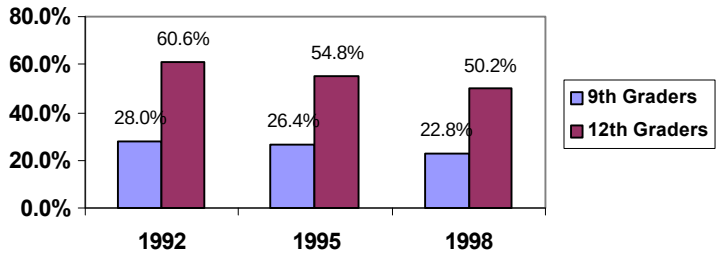
Figure 24
Percentage of students who said they drove a motor vehicle the past year after using alcohol or drugs



Source: Minnesota Planning *Children's Report Card* (1999)

Among 12th graders, Asian students were less likely than African American, American Indian, Hispanic and White students to report having had sex three or more times in their lifetime. Among 9th graders, Asian and White students were less likely than African American, American Indian, and Hispanic students to report having had sex (Fig 25).

Figure 25
Percentage of students who reported having sex at least once

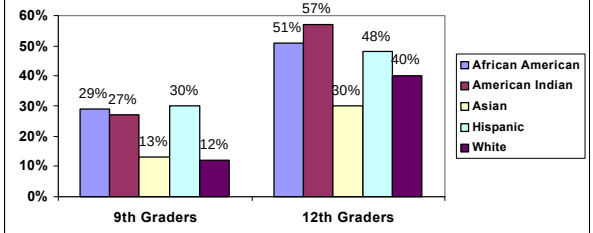


Source: Minnesota Planning *Children's Report Card* (1999)

Among 12th graders, Asian students were less likely than African American, American Indian, Hispanic and White students to report having had sex three or more times in their lifetime. Among 9th graders, Asian and White students were less likely than African American, American Indian, and Hispanic students to report having had sex (Fig 26).

Youth who engage in sex without protection are at risk for sexually transmitted diseases including HIV/AIDS. In 1996, the gonorrhea rate among females aged 15-19 years was 328/100,000 females living in Minnesota (Annie E. Casey Foundation, *When Teens Have Sex*, 1998). This compared to a national gonorrhea rate of 699/100,000 females. In 1997, there were 354 documented cases of gonorrhea among females aged 10-19 years and 123 documented cases of

Figure 26
Percentage of students who have had sexual intercourse three or more times in their lifetime (1998)



Source: Minnesota Student Survey (1998)
Analysis by Minnesota Department of Health (2000)

gonorrhea among males aged 10-19 years (Minnesota Department of Health, *Women's Health Data Book*, 1999).

Regular physical activity is a protective health behavior associated with reduced risk for developing heart disease, diabetes, obesity, anxiety, and depression. In 1998, only 68.1% of 9th grade students and 50.6% of 12th grade students reported engaging in physical activity four or more days in the previous week, suggesting the need for public health intervention to improve rates of physical activity among children and youth.

School engagement (reported above) and participation in extracurricular activities may serve as protective factors for the health and well being of children and youth. Youth engagement in scholastic, sports, religious, artistic, musical, and other positive behaviors decreases the probability of engaging in risk behaviors and provides opportunities for learning social skills, building self-esteem, and developing resiliency. In Minnesota, 86% of all children participated in extracurricular activities according to parental report. Children living in poverty were less likely than those not living in poverty to participate in extracurricular activities (74.7% versus 90.6%).

Increasing youth protective behaviors represents a major new way of thinking among Minnesotans and is occasioned in part by the desire of youth to be viewed in a more positive light rather than as a collection of problems (Minnesota Department of Health, 1999). Thus, efforts to reduce youth risk behaviors should be balanced by equally strong efforts to strengthen protective behaviors.

B. Children with Special Health Needs

1. Identifying the children with special needs population.

More than 200 chronic conditions and illnesses affect children. Some are fairly common affecting a number of children (asthma); others are quite rare affecting only a few children in the entire state (Fragile X). Estimates for the number of children with special health needs range from about 5% (picking up those with the most severe conditions or illnesses) to nearly 31% (covering a wide range of conditions and illnesses). The higher percentages would tend to include frequent or chronic ear infections and an array of mental conditions such as attention deficit disorder.

Historically, there a have been numerous ways to identify and count populations with chronic or disabling conditions. At the federal level, there are more than 40 different ways to define children with special health needs. For example, the Americans with Disabilities Act (ADA) states that disability refers to "ongoing conditions (whether physical, cognitive, behavioral or psychological) that currently have

functional consequences, but also includes conditions and illnesses that do not currently cause functional consequences because of accommodation or other type of compensation occurring at the level of the person or environment." (L. Westbrook, W. Silver and R. Stein; Implications for Estimates of Disability in Children: A Comparison of Definitional Components; Pediatrics:Vol 101, No. 6, June 1998) If the estimate for children with special needs is based on the research of Ruth Stein and colleagues, an estimated 18% of the children in Minnesota (242,000) would meet the "special health needs" definition: children with health conditions that are virtually certain to last for at least one year which causes either a) limitation in function, activity or social role or b) dependency on medication, special diet, medical technology, assistive device or personal assistance, to compensate for or minimize limitation of function or c) the need for medical care or related services over and above the usual for child's age. (Stein, R., Westbrook L., Bauman, L., The Questionnaire for Identifying Children with Chronic Conditions: A Measure Based on a Noncategorical approach; *Pediatrics,* 1997, Vol 99 N0. 4, 513-521).

Other sub-sets of the special health needs population in Minnesota include SSI eligible children (7,950 children under age 18 in 1999) and the TEFRA eligible population (3,900 in 1999). The number of children in these programs has declined due to changes in eligibility criteria. These subsets are almost mutually exclusive because children are enrolled in only one of these programs at a time.

The Minnesota Student Survey, given to students in Minnesota schools, found approximately 14% of 6^{th}, 9^{th} and 12^{th} graders identified themselves as having an impairment. State special education enrollment totals approximately 12% of the children enrolled in public or private schools. See Table 6 for categorical breakdowns in Minnesota's special education population. In addition, 2,757 infants and toddlers under three years old were eligible for early childhood intervention services in 1998.

Risk Factors: Risk factors such as those associated with maternal health and age, environment, social-economic status, may lead to higher percentages of children meeting the special health needs definitions. The extent of their impact on the population and the resultant levels of disability is complex. Please refer to 1.4 Overview of the State for a discussion of these factors.

Environmental: Environmental factors include many conditions that are based on where and how people live. Environmental factors have the potential to affect physical and intellectual growth and development which has profound effects throughout life. For example, children living in older houses may have a greater risk for lead poisoning which could lead to learning difficulties and poor health. Children who live in

households with cigarette smokers are several times as likely to develop asthma and respiratory conditions. Children who live in cities with poor air quality or close to some manufacturing complexes may also experience breathing and respiratory problems. Children who live in rural areas may be susceptible to contact with pesticides and contaminated water. Children who live in chaotic and violent situations may experience stress and a myriad of conditions/illnesses that develop or worsen due to stress.

Poverty: Intellectual and emotional development is very important during the first years of life; there is a short "window of opportunity" from the prenatal period to the first years of life where the brain is most sensitive to environmental stimulation. (Poverty and Brain Development in Early Childhood, 1997). Poor children have a greater potential for impaired brain development because of the risk factors associated with poverty. These include:

- inadequate nutrition - malnutrition causes social withdrawal, delayed motor skill development and delayed physical growth. Malnourished children score lower on vocabulary, arithmetic and reading comprehension tests.
- maternal depression - many children of these mothers lack healthy brain development and are more withdrawn, less active and have shorter attention spans.
- exposure to environmental toxins - associated with brain damage and stunted brain growth
- trauma and abuse - associated with anxiety, depression, inability to form attachments and an increased tendency toward violence later in life
- poor quality day care - often results in less frequent positive interactions and less environmental stimulation

Children from lower income families are more likely to have an activity limitation due to chronic health conditions (USA Chart book, 1999). During 1992-1995, poor children were nearly twice as likely to have an activity limitation as children living in higher income households. Limitations in activity increased for all races/ethnicity as income decreased.

Race/Ethnicity: Race and ethnicity has a significant impact on the level of chronic and disabling illnesses in the child population (Newachek, 1992). Several measures of health status and health care utilization indicate that children from lower social economic status have worse health and more risk factors associated with poor health. They also have problems accessing health care and therefore less utilization of health care. More families of color tend to fall into lower social economic levels than white families. Families of color are more likely to be poor or near poor; the poverty rate for non-Hispanic African Americans and

Hispanics was more than three times that of whites (United States Chart book, 1999). Nearly two thirds of African Americans children and 3/4 of Hispanic children are poor or near poor. These children are more likely to live in a household headed by a single parent, most often the mother. Their parents are more likely to have not finished high school (20% for African Americans and 44% for Hispanics compared to 10% for white persons) and have blue collar or service jobs. These children are at greater risk for having no insurance coverage and less likely to have seen a doctor in the past year.

2. Service Delivery Systems for CSHN in Minnesota

See Section 1.4 for a discussion of health insurance, both public and private, in Minnesota. Additionally, for families whose income is up to 275% over the federal poverty rate, MinnesotaCare is available. Benefits are comparable to Medical Assistance benefits and the premium is based on a sliding fee. Generally, children who are enrolled in Minnesota's public programs receive health care services within a managed care setting although children with special health care needs (CSHCN) are exempted from this requirement unless the family chooses to enroll in managed care. An increasing number of families with CSHCN are enrolled in managed care plans through their employer. Children with complex and frequent health care needs are a challenge for these plans. The TEFRA Option is available to middle income families with a child with special health care needs which allows the child access to Medical Assistance level of benefits. TEFRA's parental fee based on income, averaged about $600 per year in 1997 (TEFRA: Caring for our Children). Many other families have private insurance but often end up paying higher out-of-pocket costs for their CSHCN ($2,263 compared to $544). Approximately 71% of the 2,177 children enrolled in the MCSHN Treatment Program in 1999 have other coverage for medical expenses. MCSHN funding is often used to cover the cost of prescription drugs, medical supplies, copays, non-covered equipment and other out-of pocket expenses.

Changes in Medical Assistance due to welfare reform: We do not know if CSHCN are not receiving the medical care they need if their parents are dropped from Medical Assistance as they go into the workplace. There is some evidence nationally that people are not remaining on Medicaid when they go to work even though they are supposed to remain eligible.

Health Resources: Pediatricians and pediatric specialists tend to be concentrated in several medical centers (University of Minnesota, Children's Hospital, Gillette Hospital, all in the Twin Cities; and Mayo

Clinic in Rochester) or other urban centers (St. Cloud, Duluth). In the rural areas, there are far fewer resources. Often, family practitioners, general practitioners, or nurse practitioners are the primary healthcare provider.

Hospitals and the availability of emergency medical services: Non-metro families are often far from hospitals and emergency services equipped to meet their child's unique needs. Families report feeling better equipped and more knowledgeable about their child's condition than the local emergency room staff. Families sometimes by-pass local facilities to go to better equipped tertiary care centers.

Medical suppliers and assistive devices - Families look for the most comprehensive and competent providers; for many, this means going outside of their local system for services. Sometimes, families will go to the next largest city (for example to St. Cloud if they live in western Minnesota); other families travel to the Twin Cities area or arrange local deliveries. Persons knowledgeable about pediatric assistive devices and adaptions to standard equipment are scarce in outstate Minnesota.

Access to mental health services - With very few child psychiatrists and psychologists outside of the Twin Cities or Rochester, families rely on family practice physicians, adult psychologists or psychiatrists. Mental health providers have heavy case loads and it can take several months to become established as a client. Families have indicated that the appointment times has been decreased by 15 minutes in some locations, because of the increased case load demands. Other families must schedule trips to the Twin Cities for psychiatric consultations. Families stated the role of the local Children's Mental Health Collaborative varies depending on the ability to fund a continuum of services.

Out-of home placement: The number of children placed out-of-home (foster care, group homes, nursing homes, etc) decreased steadily throughout the 1980s through 1998 while the 1999 data shows a slight increase. There are indications that some of the supports that families need in order to maintain a child with special health needs in the home are eroding across the state; 514 families are on the waiting list for crisis respite services; 2,000 families have a documented need for respite services; children requiring nursing services often don't receive the authorized level of Registered Nurse services (TEFRA Report) and there is a general shortage of personal care attendants in many areas. According to the 1998 Children's Report Card, 43% of the out-of-home placements for children were due to mental health or behavioral problems.

Child care services for children with special health needs: Recent state surveys indicate that having a child with special health needs influences work-related decisions such as whether or not to change jobs or even work outside of the home. Some parents (particularly mothers) stay at home because of the unavailability of specialized child care or the high costs associated with it. (TEFRA Survey, SSI Survey, Family and Clinic Survey)

Other Trends - The following trends affect policy and service systems for CSHCN and their families:

- Increasing incidence of asthma, childhood onset diabetes, ADHD and other mental health diagnoses among children and youth.
- Increases in pediatric and adolescent AIDS and the incidence of HIV positive status.
- Aging out - more children with special needs are reaching adulthood, thus have transition needs
- IDEA and Medicaid payments
- Increased role/activities related to prevention
- Waiting lists for waiver services

During the past three years, MCSHN has conducted or participated in a number of surveys to better understand the special needs population in Minnesota. These have included the *National Family Voices Questionnaire* which focused on insurance needs and service utilization, a TEFRA survey to determine service utilization and out-of pocket costs, and a survey of families with children at risk for being removed from SSI eligibility. Table 7 summarizes some of the findings from the three studies.

The Family Voices survey was conducted jointly with Title V in a total of 20 states. Family Voices is a national grassroots organization composed of families and professional friends who care for and about children with special health care needs. Through a mailed survey conducted in 1998, the project collected information about the experiences of families of CSHCN enrolled in a variety of heath care systems. The TEFRA Survey (1996) provided an in-depth understanding of services used by children with certain disabling and/or chronic physical or mental health conditions. The third survey was a phone survey conducted of families who were in danger of losing or had recently lost SSI (Supplemental Security Income - a social security entitlement program for children with disabilities) due to changes in the medical eligibility criteria.

Table 7 Care Utilization by Children with Special Health Care Needs

Survey	Primary Care visits	Out-Pt and/or Specialist Visits	Emergency Room Visits	Hospital Stay	Out Pt Surgery	Dental Care	Home Care Services	Mental Health Provider Visits	Rx Meds	Therapies [OT or PT or Speech]
Family Voices [n = 138]	94%	87%	45%	31%	N/A	73%	21%	20%	88%	34%
TEFRA [n = 949]	75%	90%	65%	27%	72%	79%	46%	78%	67%	43%
SSI [n = 624]	60%	70%	N/A	N/A	N/A	65%	N/A	35%	63%	N/A

Sources: Family Voices, TEFRA and SSI surveys

As can be seen from the above table, these children have greater and often unique needs for health care services. The Family Voices Survey indicated that 11% of the families did not believe their primary care physician had the skills and experience needed to manage the care of CSHCN. Of those receiving mental health services, 37% reported problems accessing the services. Forty-eight percent of the families whose children received in-home health care services reported problems with these services. Families related that having a child with special health needs had impacted both work and financial aspects of the family's life with 35% of the families reporting and that the child's condition caused financial problems. Thirty-nine percent of the respondents said they had to cut down on working outside of the home to care for their child. Finally, 32% reported they need additional income to cover their child's medical expenses.

The TEFRA survey results provide a picture of the total costs and payment sources for services these children received. Families of CSHCN need the help of TEFRA to finance acute care which is either not covered by private health plans, or is covered but with high co-pays and deductibles. In addition, TEFRA funds were used for many long term care supports needed by the children and their families which are not typically covered by private health plans. Children with complex health care needs in the TEFRA program are likely to be experiencing multiple diagnoses and conditions impacting all facets of their daily lives. Dependence in activities of daily living, ongoing medical treatments, increased need for supervision, frequent hospitalizations and frequently missed school days are the realities confronting children on TEFRA. The presence of a chronically ill or disabled child in the family also affects parental employment,

family income, place of residence, and relationships with extended family and the larger community. Basic care for these children includes a myriad of acute care providers and ongoing chronic care providers. Beyond basic care needs, the children can require supports that make it possible to remain with their families and to function successfully within their communities.

Welfare reform legislation in 1996 also included narrowed definition of disability for children eligible for SSI. The new definition caused 1466 Minnesota children to lose their benefits beginning in 1997. The SSI Survey was conducted soon after families were informed that their child would most likely lose SSI benefits. Families were already starting to lose or forgo services and care for their child. Mental health service loss was particularly notable due to increased cost and insurance limitations.
The children and their families remain below or at poverty level even with SSI. Families used the SSI funds to access better food, clothing, shelter and medical care for the child with special needs. Almost one fourth of the children in this study had identified needs that are not met by their insurance or Medicaid. The highest unmet needs were mental health care, medical care, and specialist care.

Minnesota's Collaboration Conference is an annual gathering of professionals and families involved with interagency service systems for children with special needs. There are speakers and work sessions on a number of topics regarding systems for children with special health needs including early childhood intervention and special education, current research, and model programs. Approximately 450 individuals attend the three day conference annually. In January 2000, a MCSHN survey was included with the conference packet for all attendees. By the end of the conference, 92 surveys were returned. Demographic characteristics of the respondents are presented in Table 8.

Table 8 Characteristics of Respondents to Collaboration Conference Survey

Parent or guardian of a child(ren) with special needs	25.3%
Member of a local Interagency Early Intervention Committee	67.3%
Staff from local public health agency	16.5%
Staff from county human services or social services agency	26.4%
Staff from local school system	28.6%
Member of a local Community Transition Interagency Committee	14.3%
Member of a mental health or family service collaborative	17.6%
Staff from state agencies	2.2%

The majority of the respondents had heard of MCSHN (87%) and were familiar with many of its services and programs. They were most familiar with funding for diagnostic evaluations (55.3%); information and referral hotline (42.5%); early childhood intervention (45.3%); and funding for treatment services (40.0%). They were least familiar with MCSHN Issue Briefs (7.6%); assistance for electricity and medical travel expenses (18.8.%) and published Guidelines of Care (20.9%). They were somewhat familiar with other MCSHN program activities such as the TEFRA Report, medical and rehabilitation clinics, parent and provider workshops and resource materials.

Ninety-six percent stated that general and specific information for parents and professionals would be helpful, with additional assistance on how to access information. Respondents recommended MCSHN provide more information to education professionals in the K-12 system. There were questions about updating the Guidelines of Care for some conditions and suggestions to develop Guidelines for Down Syndrome, Autism, Cerebral Palsy and Persistent Developmental Delay.

Other informational needs included information on assistive devices and technology, child friendly brochures and books about specific conditions, information on rare disorders and living with a traditional "childhood disorder" as an adult. Respondents suggested increased marketing of MCSHN materials, clinic sites/dates, workshops and referral procedures for MCSHN clinics. There also several recommendations that MCSHN's treatment program provide more funding for mental health services.

Direct mailing of pamphlets or brochures was rated the most effective method (68.6%) to communicate with parents and professionals; followed by 1-800 information hot lines (48.5%), meetings or workshops (40%), through doctor's or other provider offices (31.4%) and the Internet Website (31%).

When queried about the adequacy of their health plans, the following issues were identified (a) lack of coverage or limitations and caps for services (case management, mental health assessments and treatment, therapies, technology and assistive devices); (b) lack of choice for both primary and specialty physicians; (c) difficulty in getting referrals (both in-network and out-of-network); (d) paperwork associated with getting insurance (MA and TEFRA) or referrals; (e) high copays and deductibles, and (f) penalties for using out-of network providers. Several remarked that they needed to advocate for services and that parents have difficulty in appealing denials. See Table 19 for more results.

Table 9 Collaboration Conference Survey

How well does insurance meet health needs?	**Excellent**	**Good**	**Okay**	**Poor**
Offering benefits that meet the child's needs	3.5%	29.1%	34.8%	20.9%
Providing skilled and experienced specialty doctors	3.5%	31.8%	29.4%	22.4%
Providing skilled and experience therapists such as occupational therapists, physical therapists and speech therapists	8.3%	23.8%	28.6%	25.0%

Most parents and professionals rated collaboration with primary physicians poor (38.7% for professionals and 13.9% for parents) or fair (32% for professionals and 33.3% for parents). A number of barriers were listed with time constraints being the foremost. Respondents remarked that with current time constraints, physicians lack the time to do complete assessments, return calls from education professionals, and generally were difficult to engage in problem solving and in-depth discussions. Another barrier is that primary care physicians do not consider themselves part of a team either because of time constraints, adherence to a medical model, lack of understanding of education systems, or lack of respect for other professionals or parents.

There were many recommendations for improving collaboration with primary care physicians including increased training and education opportunities on the benefits of collaboration and early intervention and outreach in the form of brochures, and newsletters.

Since August 1999, all families approved for MCSHN's treatment or evaluation programs and

clinic attendees have been asked to complete a survey. Included were questions regarding medical home (availability of primary physician and specialty services, service coordination and length of time with the provider), service utilization, degree of dependence for daily living activities (bathing, dressing, transportation, learning, etc), and priority needs. By the end of January 2000, 333 surveys had been received. The survey results revealed that families enrolled on the MCSHN treatment program utilize a number of services. See Table 10.

Table 10: Service used by CSHN, 1999

Services	Percent
Medication(s)	59.3%
Medical supplies	39.6%
Special diet	30.2%
Speech therapy	29.0%
Equipment	25.7%
Specialty Medical Care	21.4%
Occupational therapy	20.9%
Physical therapy	19.5%
Mental health care	9.2%
Diapers (over the age of 4)	9.0%
Skilled nursing care	6.4%
Personal Care Attendant (PCAs)	4.1%

Source: MDH, 2000

Table 11 represents the priority needs identified by families enrolled in MCSHN programs.

Table 11: Priority Needs of MCSHN Families

Financial resources to help pay for our child's special needs.	3.8
Information on services available for our child and family.	3.6
Information on our child's disability.	3.3
Paying for dental care	3.2
Paying for medical care.	3.2
Adequate health insurance for our child.	3.1
Financial resources to pay for special equipment for our child.	3.0
Professionals who will respect my individual needs, choices and values.	3.0
Information or resources for training to enhance our care giving.	3.0
Planning our child future service needs.	3.0
Additional money for the basics our family needs or to pay bills	2.8
Getting assistance in accessing services, service coordination, or case management	2.5
Professional counseling for our child.	2.4
Locating a dentist who will accept a special needs child	2.3
Locating medical care	2.2
Home modifications	2.2
Trained medical professionals who will come to our home to provide care: (nurses, PCAs's.)	2.0
Temporary care giving relief or respite.	2.0
Vehicle modifications	1.9

Ongoing child care	1.9
Purchasing special diets or formulas.	1.7
Purchasing special clothing.	1.5

Summary of MCSHN potential priority areas

The following priority areas were identified by the needs assessment process:

- Enhance activities for early identification of CSHCN and a system for tracking their progress
- Increase the percent of CSHCN that have and utilize a medical home
- Improve service coordination
- Improve access to quality, comprehensive and multi-disciplinary services, especially for children/families in greater Minnesota
- Improve supports for families with CSHCN (e.g. home and vehicle modifications, specialized child care services, respite care, skilled nursing care, other financial assistance)
- Support community-based rather than institutionally-based services and insure adequate funding for community-based services
- Increase participation and collaboration with mental health systems to improve awareness of mental health issues and services for children
- Improve systems that provide information and training about disabling conditions through a variety of methods (Information and Referral toll-free number, condition- specific publications, web sites, links to other resources, training, parent support groups
- Active participation in the development of the coordinated and integrated interagency systems of services for children ages 0-21. Improve communication, coordination and collaboration between systems that provide services to children with special health needs and their families (Educational Services, Human Services, Community Health, managed care organizations, professional organizations, etc.)
- Increase awareness of cultural diversity, family needs/concerns, and humanitarian issues. This includes focusing on issues related to recent immigrants and outreach to communities of color.
- Increase role in development of systems for adolescents with special health needs that provide transition services and promote independent living skills.
- Expand insurance coverage or develop funding sources for medical services, supplies, devices that are needed by CSHCN (van lifts and other wrap-around services such as home

modifications, ramps, developmental toys, etc.).

- Monitor the increasing trend of placing CSHCN in managed care organizations with a goal of having a more integrated service delivery system.

3.1.2.2 Direct Health Care Services

No direct services are provided through Maternal and Child Health programs, except to children with special health care needs. See section which follows.

A. Children with Special Health Care Needs. Respondents to the *MCH/MCSHN Priority Needs Menu* endorsed early identification and early intervention for CSHCN as high priorities. In addition, parents of CSHCN who participated in the Wilder Focus Groups identified respectful provision of services and consideration of the special needs of their children as key areas for improved direct services. Appropriate referrals without delay or inordinate paperwork were also expressed as key needs by the focus group participants. For CSHCN, access to services (see Section 3.1.2.3) and coordination of services (see Section 3.1.2.5) are highly desired and are viewed as integral components of direct service delivery.

B. Allocation of MCH Resources for MCH Priority Needs: Direct Services. At present, Direct Services are provided for the following MCH priority needs.

- Increase percent of children whose disability is identified early
- Increase percent of children who receive early intervention services.

This allocation of resources is consistent with the identification of priorities by respondents to the *MCH/MCSHN Priority Needs Menu*. Thus, MCSHN's current practices of providing reimbursement for 1) diagnostic and treatment services, 2) medical and rehabilitative clinic services, and 3) family support, information, and referral were supported by the expressed desires of those who responded to the *Priority Needs Menu*. Continuous quality improvement in these two priority areas is warranted.

3.1.2.3 Enabling Services

A. Health Care Access. Concerns regarding access to health care and health-related services were previously discussed in Section 3.1.2.1 under the topical headings of: *Access to Health Services*, *Poverty*, and *Homelessness, Affordable Housing, and Food Security* (p. 84). Additional concerns were expressed by focus group participants in the Wilder Research Center report *Keeping Families Healthy: Findings from focus groups with low-income Minnesota parents.* Key recommendations of the report which are related to enabling services are presented below.

1. Decrease Fragmentation in Health Insurance Coverage

- Provide consistent, affordable health insurance coverage for low income working families by: (a) reducing premium and co-pay costs for those who cannot afford them, and (b) expanding eligibility requirements for Minnesota Care and Medical Assistance
- Simplify application procedures and eligibility requirements for public health insurance programs. Educate the public about these programs
- Promote health plans that cover a wide variety of needed services, including dental, optical care and mental health care
- Promote systems that allow families to consistently see one primary care provider

2. Improve Service Delivery

- Train health care providers and other helping professionals to be respectful, honest, caring, and approachable
- Train dentists to understand child behavior
- Train parents to be effective advocates and navigate the health care system
- Train school staff, medical providers, and social workers to value the knowledge and strengths of parents of children with special health care needs, and to respect their advocacy efforts
- Expand transportation services offered by health plans and clinics
- Reduce waits at emergency rooms and medical and dental clinics
- Expand clinic hours to meet needs of working families
- Provide more translation services in medical and dental facilities
- Provide reminders to parents to schedule and keep appointments for routine care
- Integrate basic public health services with school systems
- Ensure needed special education services are available
- Support teen pregnancy prevention efforts that educate adolescents about the consequences of early childbearing through hands-on experience with infants
- Expand access to free and low-cost confidential, family planing services.
- Provide more low income families with one-on-one advocacy and support from public health nurses

Health System Changes Impacting MCH Populations. Welfare reform, shifts in Medicaid coverage, and the movement to managed care systems have coincided with implementation of MinnesotaCare and favorable economic conditions in the state and nation. Thus determining the independent effects of welfare reform, changes in Medicaid coverage, or the move to managed care is difficult. These major changes in the health service delivery system have not been systematically evaluated in isolation from other factors which influence maternal and child health. Currently, no adverse effects of welfare reform, shifts in Medicaid coverage, or the move to managed care are being detected.

Allocation of MCH Resources for MCH Priority Needs: Enabling Services

At present, Enabling Services are directed towards the following MCH Priority Needs:

- Promote healthy parenting/family development throughout childhood and youth
- Reduce teen pregnancy and teen birth rate
- Reduce child abuse and neglect

Additional services are needed to address the following priority needs:

- Reduce drug, alcohol and tobacco use
- Address the multi-faceted needs of teen parents
- Reduce youth risk behaviors
- Improve mental health of children, youth and parents

3.1.2.4 Population-Based Services

Health Promotion for MCH Populations. The concept of health promotion was clearly endorsed by respondents to the MCH Priority Needs Survey (Appendix Q.). The concept of health promotion implies a population-based approach which may require some shift in how MCH programs operate at the state and local levels.

A key recommendation of the Wilder Research Center focus group report (Appendix O.) which is related to population-based services is: Promote Family Support and Healthy Community Conditions. This includes the following components:

- Increase the supply of affordable housing and child care
- Eliminate discrimination based on race, class, or other characteristics within the health care, social service, and educational systems

- Promote male involvement in family planning and child rearing
- Expand access to respite care

- Increase public awareness of mental health problems and resources; provide culturally specific information for immigrant groups

Allocation of MCH Resources for MCH Priority Needs: Population-Based Services.

At present, there is little emphasis on population-based services in Minnesota, with more resources being directed to Enabling Services–especially to programs for higher risk women and children. Population-based services that are currently provided address the following MCH Priority Needs:

- Reduce drug, alcohol and tobacco use
- Reduce youth risk behaviors
- Reduce teen pregnancy and birth rate
- Reduce child abuse and neglect

Additional emphasis is needed at the population level for the following MCH Priority Needs:

- Promote family support and healthy community conditions
- Promote healthy parenting/family development throughout childhood and youth
- Improve mental health of children, youth and parents

3.1.2.5 Infrastructure Building Services

Improving health systems coordination. Wilder Research Center focus group participants commented on the fragmentation of health services and expressed the desire for seamless health services. To fulfill that need, improved coordination of services is warranted–with greater linkages across programs that serve women and children. This need is being addressed in part by the Minnesota Health Improvement Partnership (MHIP). The purpose of MHIP is to provide an organized structure for statewide discussions of population health issues and projects that cross the boundaries between the state and local public health system, managed care organizations and other health care providers, counties, Regional Coordinating Boards, educational institutions, state agencies, and other community organizations. The MHIP has representation from a broad base of constituencies representing a wide range of perspectives and serves in an advisory role to the Minnesota Department of Health on selected issues. Convening MHIP is part of a set of coordinated activities the MDH and its key partners plan to undertake to operationalize the vision of

a coordinated health system in Minnesota. Additional collaborations of relevance to maternal and child health are summarized in Appendix S. Interagency Collaboration Related to Maternal and Child Health.

These collaborative efforts represent important aspects of coordinating MCH health services. Efforts to improve interagency communication related to indicators of child health and well being have resulted in the development of a KIDS Gateway (see www.mnkids.org), whereby policy makers, program managers, and citizens can gain easy access to child health and well being indicators.

Community, Parental, and Child Participation in Health System Coordination. The direct involvement of parents and children from a broad spectrum of communities, including communities of color and new immigrants, in collaborative efforts to improve health system coordination is warranted. Consumers of MCH services can play an important role by identifying needs for improved service coordination and planning ways to implement the improved coordination. Invaluable information for the MCH Needs Assessment 2000 was garnered from focus groups of consumers that were conducted across the state. A future challenge will be to further involve consumers in planning and implementing changes to the health delivery system in order to better meet their needs.

Performance Measures for MCH Populations. From a performance standpoint, it is difficult to isolate the effects of one component of the health system from all other components. However, the overall effects can be judged on the basis of key health indicators (see www.mnkids.org), health status indicators (see this report), and performance measures (see this report). Increased capacity to measure the performance of MCH programs is a major achievement of the federal, state, and local health agencies over the past five years.

Allocation of MCH Resources for MCH Priority Needs: Infrastructure-Building Services

At present, Infrastructure-Building Services in Minnesota are directed towards improved capacity for MCH needs assessment and for the following MCH Priority Needs:

- Reduce drug, alcohol and tobacco use
- Reduce child abuse and neglect
- Reduce teen pregnancy and teen birth rate
- Reduce youth risk behaviors

Additional services are needed to meet the following MCH Priority Needs

- Promote family support and healthy community conditions
- Promote healthy parenting/family development throughout childhood and youth
- Improve mental health of children, youth and parents

3.2 Health Status Indicators

3.2.1 Priority Needs

The priority needs were identified through a process that culminated in the statewide mailing of the *MCH/MCSHN Priority Needs Menu* (Appendix Q.) to members of the Maternal and Child Health Advisory Task Force and MCH Needs Assessment 2000 Work Group, local public health agencies, and public health nursing directors. The menu was developed by MCH and MCSHN staff based on the recommendations of the Work Group and Advisory Task Force. Items included in the menu were derived from the *MCH Indicators Menu* results and the findings and recommendations of focus groups conducted by the Wilder Research Center, the Minnesota Department of Health, the Urban Coalition, and MOAPP. See Appendix R. for a full report of the *MCH/MCSHN Priority Needs Menu*.

The priority needs so identified include:

Reduce drug, alcohol, and tobacco use

Promote family support and healthy community conditions

Promote healthy parenting/family development

Reduce child abuse and neglect

Reduce teen pregnancy and teen birth rate

Address the multifaceted needs of teen parents

Increase percent of children whose disability is identified early

Reduce youth risk behaviors

Improve mental health of children, youth and parents

Increase percent of children who receive early intervention services

3.3 ANNUAL BUDGET AND BUDGET JUSTIFICATION

3.3.1 COMPLETION OF BUDGET FORMS

Please see Forms 2-5.

3.3.2 OTHER REQUIREMENTS

Minnesota's maintenance of effort from 1989 is $6,184,197. The budget documents that Minnesota

has exceeded this level of effort for FFY 2001. Specific amounts for continuation of consolidated health programs and special projects in effect before August 31, 1981 are determined by Minnesota Statute (See Appendix F.).

Other sources of federal MCH dollars come from the Maternal and Child Health Bureau (MCHB), the Centers for Disease Control and Prevention, the Department of Agriculture, the Department of Education, and the National Highway Traffic Safety Administration. MCHB supports the State Systems Development Initiative and Abstinence Education programs. The Centers for Disease Control and Prevention funds the Preventive Block Grant, the REACH (Racial and Ethnic Approaches to Community Health) project, the Coordinated School Health program, prenatal nutrition surveillance system, diabetes, traumatic brain injury surveillance, emergency room surveillance, 5-A-Day Power Plus, arthritis, and burn injury. The Department of Agriculture supports the Supplemental Nutrition Program for Women, Infants and Children (WIC) program and the Commodity Supplemental Food Program (CSFP). The Department of Education funds the Part C (formerly Part H) program. The National Highway Traffic Safety Administration funds the CODES project.

It should be noted that while the Division of Family Health is the recipient of all the funds described above, not all of the funds are administered by the MCH or MCSHN Sections. The Supplemental Nutrition Programs Section, and the Center for Health Promotion administer a portion of these funds. However, all the funds impact the MCH population and are under the control of the Family Health Division Director.

The sources of matching funds include the state General Fund and local sources, the greatest of which include state Community Health Service subsidy, local tax revenues and Medical Assistance reimbursements. State General Fund dollars also support additional MCH-related activities such as the Minnesota Healthy Beginnings program, the Infant Mortality Reduction Initiative, the ENABL program, MCSHN clinics and treatment, tobacco use prevention, the Fetal Alcohol Syndrome initiative, and Project WOLF.

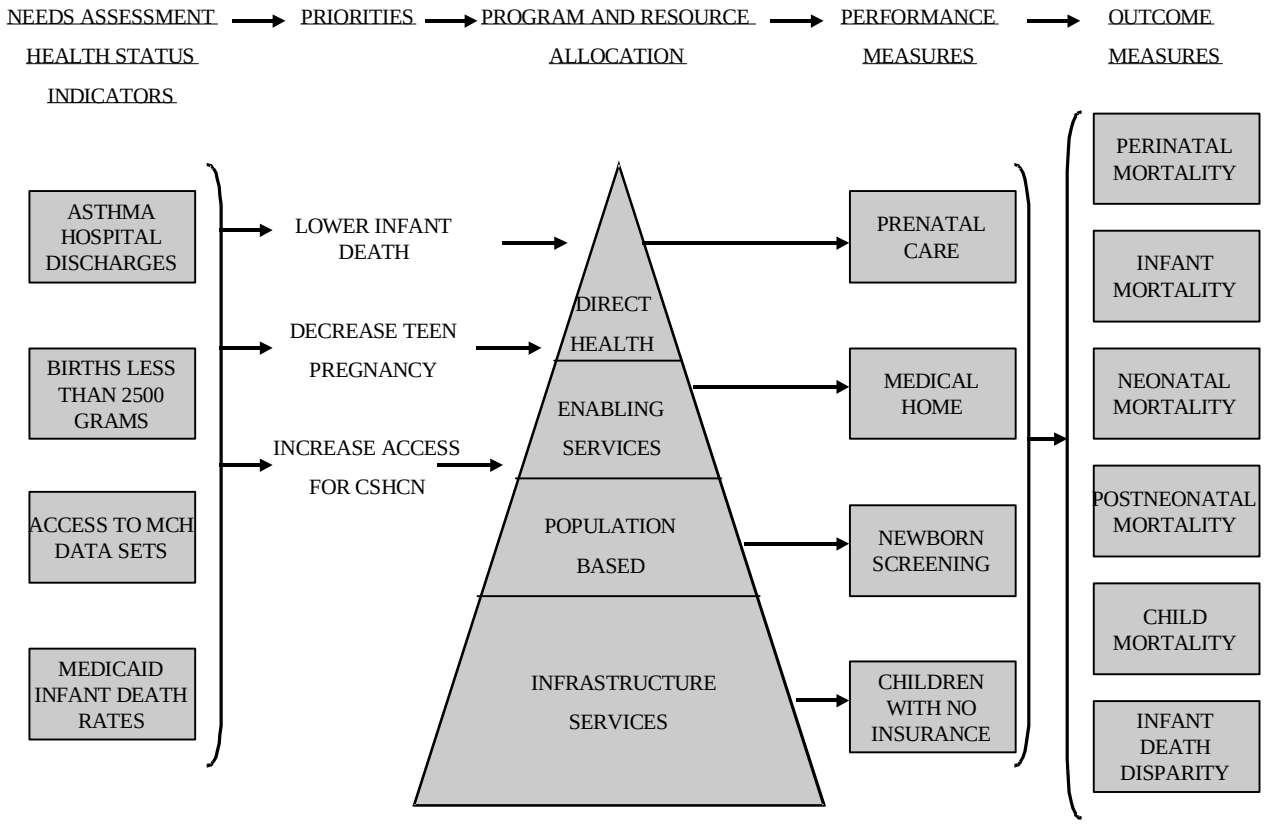
3.4 PERFORMANCE MEASURES

3.4.1 NATIONAL "CORE" FIVE YEAR PERFORMANCE MEASURES

See Figure b which follows:

Figure b

TITLE V BLOCK GRANT PERFORMANCE MEASUREMENT SYSTEM



3.4.1.1 FIVE YEAR PERFORMANCE TARGETS

Please see Form 11

Figure c which follows lists the national "core" performance measures" by category and type.

Figure c

PERFORMANCE MEASURES SUMMARY SHEET

CORE PERFORMANCE MEASURES	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.	**Y**				**Y**		
2) The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.	**Y**				**Y**		
3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home."		**Y**			**Y**		
4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g., the sickle cell diseases) (combined).			**Y**				**Y**
5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.			**Y**				**Y**
6) The birth rate (per 1,000) for teenagers aged 15 through 17 years.			**Y**				**Y**
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			**Y**				**Y**

CORE PERFORMANCE MEASURES	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
8) The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.			**Y**				**Y**
9) Percentage of mothers who breastfeed their infants at hospital discharge.			**Y**				**Y**
10) Percentage of newborns who have been screened for hearing impairment before hospital discharge.			**Y**				**Y**
11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN Program with a source of insurance for primary and specialty care.				**Y**	**Y**		
12) Percent of children without health insurance.				**Y**	**Y**		
13) Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.				**Y**		**Y**	
14) The degree to which the State assures family participation in program and policy activities in the State CSHCN Program.				**Y**		**Y**	
15) Percent of very low birth weight live births.				**Y**			**Y**
16) The rate (per 100,000) of suicide deaths among youths aged 15 to 19.				**Y**			**Y**
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				**Y**			**Y**
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				**Y**			**Y**

NEGOTIATED PERFORMANCE MEASURES	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) Number of local public health agencies which track children with identified risk factors which may lead to chronic illness/disability.				**Y**	**Y**		
2) The percentage of children and adolescents enrolled in health plans who receive comprehensive preventive health visits according to nationally accepted standards.		**Y**				**Y**	
3) Incidence of injury (violence/unintended; fatal/non-fatal) to all MCH populations.			**Y**				**Y**
4) Incidence of substantiated child maltreatment by persons responsible for a child's care.			**Y**				**Y**
5) Percent of pregnancies that are unintended.	**Y**						**Y**
6) Percent of women who use alcohol, tobacco and other drugs during pregnancy.			**Y**				**Y**
7) The number of counties with a Children's Mental Health Collaborative or a Family Service Collaborative.				**Y**	**Y**		
8) The percentage of MCH plans that include objectives and methods to eliminate the disparity in health status between populations of color and the majority population		**Y**				**Y**	
9) Proposed New State Performance Measure Realted to Youth Risk Behavior Reduction			**Y**				**Y**

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services

IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

3.4.2 STATE "NEGOTIATED" FIVE YEAR PERFORMANCE MEASURES

3.4.2.1 DEVELOPMENT OF STATE PERFORMANCE MEASURES

Please see Form 11

3.4.2.2 DISCUSSION OF STATE PERFORMANCE MEASURES

The discretionary performance measures described below culminated from a process designed to assure selection of measures based upon the views of the broad array of MCH stakeholders. External work group members who participated in the process included representatives from local public health agencies, the Department of Human Services, Children's Defense Fund - Minnesota, MDH's Office of Minority Health, local health care providers, and the University of Minnesota School of Public Health.

SP #1 Number of local public health agencies which track children with identified risk factors which may lead to chronic illness or disability. (Infrastructure building services)

This measure was chosen because periodic monitoring and assessment of infants and toddlers at risk for health or developmental problems ensures early identification, support and services. The process improves the chances of identifying health or developmental problems before the child reaches school age; prevents the onset or reduces the impact of secondary complications; facilitates early intervention services for the child; affords parents support at a critical time and assures that the child receives more than one examination by a qualified professional. Public health involvement may help reduce fragmentation of services for children with special needs.

SP#2 The percentage of children and adolescents enrolled in health plans who receive comprehensive preventive health visits according to nationally accepted standards. (Enabling services)

This performance measure was chosen because periodic visits for infants and annual visits for older children and adolescents is one of the best methods for detection of physical, developmental, behavioral or emotional problems so appropriate treatment can be given, as well as providing opportunities for health promotion and disease prevention and education.

SP# 3 Incidence of injury (violence/unintended; fatal/non-fatal) to all MCH populations. (Population-based services)

This performance measure was chosen because unintentional injury and violence are the leading causes of morbidity and mortality in children and youth of both genders, and among women through the age of 34 in Minnesota. Injuries are sometimes the result of inadequate nurturing/supervision of children, unhealthy environments and risk-taking behavior. Injuries are also the largest cause of death among children aged 1-14.

SP# 4 Incidence of substantiated child maltreatment by persons responsible for a child's care. (Population-

based services)

This measure was chosen because child maltreatment has devastating effects on its victims. While Minnesota's rate of substantiated child maltreatment does not appear alarming when compared to the Healthy People 2000 goal, children with disabilities are nearly twice as likely as their same-aged non-disabled peers to be victims of maltreatment. In addition, there is a 10 fold difference in likelihood of maltreatment between the lowest risk racial group (Asian) and the highest risk racial group (African American). Maltreatment is the antithesis of adequate nurturing.

SP# 5 Percent of pregnancies that are unintended. (Direct health care services)

This measure was chosen because pregnancy intendedness is directly related to pregnancy outcome, infant mortality and child health outcomes.

SP# 6 Percent of women who use alcohol, tobacco, and other drugs during pregnancy. (Population-based services)

This performance measure was chosen because health professionals concur that tobacco, alcohol and other drug use during pregnancy is injurious to the fetus and profoundly affects pregnancy outcomes.

SP#7 The number of counties with a Children's Mental Health Collaborative or a Family Service Collaborative. (Infrastructure building services)

The Collaboratives are intended to foster cooperation and help communities come together to improve results for Minnesota's children and families. By providing incentives for better coordination of services, Minnesota hopes to increase the number and percentage of babies and children who are healthy, children who come to school ready to learn, families able to provide a healthy and stable environment for their children and children who excel in basic academic skills. The Collaboratives are intended to support parents in their roles as nurturers of children; promote healthy environments and facilitate access to services.

SP# 8 - Percentage of MCH plans that include objectives and methods to eliminate the disparity in health status between populations of color and the majority population. (Enabling services)

While enjoying overall good health status, Minnesota has some of the worst racial/ethnic disparities in health status in the country.

SP#9 - Proposed new state performance measure related to youth risk behavior reduction. Related to the

needs assessment priority "Reduce youth risk behaviors". A new state performance measure will be developed for inclusion in the FFY 2002 application.

3.4.2.3 FIVE YEAR PERFORMANCE TARGETS

Please see Form 11

3.4.2.4 REVIEW OF STATE PERFORMANCE MEASURES

Minnesota's selection of state performance measures was discussed at the August 1998 review meeting of MCHB staff, Region V staff and MDH staff.

3.4.3 OUTCOME MEASURES

Please see Form 12

IV. REQUIREMENTS FOR THE ANNUAL PLAN

4.1 PROGRAM ACTIVITIES RELATED TO PERFORMANCE MEASURES

Please see Form 11 for performance objectives. The following narrative describes activity plans for each.

DIRECT HEALTH CARE SERVICES

A. <u>Pregnant Women and Infants</u>

SP #5 - Percent of pregnancies that are unintended

Title V activities which relate to this performance measure and priority need "Reduce teen pregnancy and teen birth rate", Form 14, include family planning method services and efforts to enhance them.

The Family Planning Special Projects grant program will continue. For the CY 2000-2001 grant cycle $10,063,405 was awarded to sixty-one (61) projects statewide.

A family planning workgroup has been established for 1999-2000 to advise the Department on program improvements for the Family Planning Special Projects grant program and on issues related to the overall family planning system based on recommendations in the System-wide Analysis of Family Planning in Minnesota Report. The workgroup has reviewed the program goals, funding allocation formula and grant making process. Recommendations for program improvements will be submitted to the Department in the summer of 2000.

The Maternal Child Special Project grants application process for CY 2000-01 was conducted in 1999. Funding levels allocated are decreased from the previous cycle, however agencies will continue to provide family planning medical method services.

B. Children and Adolescents

SP #2 The percentage of children and adolescents enrolled in health plans who receive comprehensive preventive health visits according to nationally accepted standards.

Title V activities which relate to this performance measure and priority need "Promote family support and healthy community conditions," Form 14, include support of the EPSDT program, funding for community-based services, and leadership to promote systems change.

Title V will continue collaboration with the Department of Human Services in the planning, development and evaluation of the components and standards of the Child and Teen Checkup Program (Minnesota's EPSDT program). Through formal and informal relationships with DHS, Title V provides technical support to public and private Child and Teen Checkup providers, and to Outreach Coordinators in their efforts to inform clients and providers regarding C&TC. Also, in collaboration with the Department of Human Services and health plans, Title V provides statewide training for MA managed care and fee for service providers in an attempt to decrease barriers. Child and Teen Checkup training sessions continue to be updated and offered for public and private providers focusing on components, standards, assessment, and anticipatory guidance. On site consultations by a Certified Pediatric Nurse Practitioner for the newly trained C&TC nurses will continue.

Continued efforts between Title V, the Department of Human Services, the Department of Children, Families and Learning, and the Department of Economic Security will focus on supporting and coordinating screening activities of Child and Teen Checkups, Early Childhood Screening, and Headstart.

Preventive health services, based on nationally accepted standards, will continue to be provided to children and adolescents in school-based clinics in Minneapolis and St. Paul and community-based clinics in Minneapolis. The Minnesota Department of Health will continue to provide Title V funding and technical assistance to support the health services in these settings.

The Minnesota Adolescent Health Action Plan, which provides a framework for youth health planning, health status and related statistics, a review of sound adolescent health practices and strategies, and recommendations for action and available resources, will be available in early fall, 2000. The state adolescent health coordinator in conjunction with other MDH staff will promote the use of the plan and provide technical assistance, consultation and training to local public health and community agency staff.

Specific areas of concern in adolescent health will continue to be addressed in conjunction with appropriate internal and external partners, e.g. the Adolescent Health Services Action Team, a workgroup of the Minnesota Health Improvement Partnership, currently developing recommendations to improve the adolescent health care service system in Minnesota.

The Title V program will continue to provide leadership to the *Adolescent Health Care Coalition*, a collaborative of health care providers, health plans, health associations, government, public health, hospitals, foundations and non-profit agencies working to change the health care system to better meet the health needs of adolescents. This will be done by promoting the adoption of a preventive health model among all segments of the health care system.

MCH will also continue to provide leadership and technical assistance to the Metropolitan Health Plan in its Public Health Collaborative on Adolescent Health Care. The goal of this collaborative is to increase the demand for annual preventive health visits for adolescents among teens, parents and health providers.

The State Adolescent Health Coordinator is currently providing leadership and direction to the State Adolescent Health Coordinators Network in conjunction with the Association of Maternal Child Health Programs (AMCHP), the CDC Division of Adolescent and School Health (DASH), the Maternal and Child Health Bureau (MCHB), and the National Adolescent Health Information Center (NAHIC).

Major obstacles to increasing the level of well-child visits and adolescent well-care visits would include erosion of employer-based insurance, especially non-ERISA employer insurance; lack of consensus over the periodicity and content of preventive well-child/adolescent care; data collection and publication issues; and affordability of insurance coverage.

C. Children with Special Health Needs

NP #1- The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs Program

Title V activities which relate to this performance measure and priority need "Increase percent of children who receive early intervention services," Form 14, include allocation of funding to assure access and core public health functions.

Sarah Thorson's piece???? In previous years, access to a medical home was measured in terms of a child with special needs' visits to a primary care provider for a well-child check. If that was the only criteria for access to a medical home, Minnesota would be on target for achieving its original goal. This criteria is easily measured, but does not lend itself to substantive interpretation. MCSHN program

activities this year have focused on 1) gathering data that more accurately reflects the "medical home" criteria defined by the American Academy of Pediatrics and 2) evaluating current resources and developing new resources to support a broader understanding of "medical home" on the part of physicians. Because of the change in how MCSHN measures access to a medical home, trends over time are not measurable.

Almost no SSI eligible children are dually enrolled in the MCSHN treatment program. Children on SSI in Minnesota are eligible to apply for MA at their county family service agency. Almost all who apply are eligible and can access a comprehensive set of MA benefits which exceed the benefits available to them from MCSHN.

In Minnesota this is a complex issue. Because Medicaid eligibility is not automatic for those children eligible for SSI but requires a separate application there are at any one time between 13 to 20 plus percent of the SSI population who do not have Medicaid eligibility. Our survey of the population of SSI recipients who had lost their SSI eligibility because of the new eligibility criteria showed that families do not have Medicaid coverage for a variety of reasons. Some didn't go and apply, others say they didn't know about Medicaid, there were some who were incorrectly told they were not eligible for Medicaid, another group said that it was too much paperwork, and others wanted to pay for their own private insurance or pay premiums for MinnesotaCare verses being on a "welfare" program. The lack of health care coverage for some children and the fact that information regarding the application process for Medicaid is not always correctly conveyed to families is a concern for MCSHN. This year we hope to open discussions again with Medicaid staff at DHS regarding Minnesota becoming a state that links Medicaid and SSI eligibility.

Making changes in the linking of SSI and Medicaid will be difficult in Minnesota. Minnesota has 209 (b) status. This means it uses different and more restrictive Medicaid eligibility requirements which pre-date SSI. When this status was chosen in 1972 there was concern about the number of elderly and disabled recipients, so the state chose to use the financial standards and definitions of disability in effect in January of 1972, rather than making all SSI recipients automatically eligible for Medicaid. It is going to be difficult to convince policy makers at DHS that this is needed for children with its increased cost to the state.

NP #2 - The degree to which MCSHN provides or pays for specialty and sub-specialty services, including care coordination not otherwise accessible or affordable to its clients.

Related to this performance measure and priority need "Increase percent of children who receive early intervention services," Form 14, Title V funds are used to assure access. MCSHN currently provides

for specialty and subspecialty services through nine types of field clinics and payment to private care providers. For FFY 2001, diagnostic evaluations will be provided to any child, birth to 21, with a suspected chronic or disabling condition without regard to income. The MCSHN Clinic Program will evolve in conjunction with an ongoing clinic needs assessment. Care coordination is provided by some local Community Health Boards (CHB) through the Title V MCH Special Project grants and other state and local dollars. Technical assistance regarding care coordination and medical funding sources will continue to be provided to a variety of local agencies and families by MCSHN staff on an ongoing basis. All entities in contact with children and families will be provided with information about MCSHN diagnostic evaluation, treatment, and clinic services.

An obstacle impacting achievement of these activities revolves around MCSHN retaining a sufficient level of staffing. Adequate federal and state funding, recent retirements and other staff turnover may affect MCSHN's ability to provide the technical assistance to local Community Health Boards, provide trainings regarding funding sources, and staff the clinic program.

ENABLING SERVICES

A. Pregnant Women and Infants

NP #15 - Percent of very low birth weight live births

Title V activities which relate to this performance measure and priority need "Promote healthy parenting/family development throughout childhood," Form 14, include community-based pregnancy testing and extensive support of enabling services.

Local Community Health Boards will carry out a variety of activities aimed at decreasing the number of low-birth weight and very low-birth weight births. Many CHB will offer free pregnancy testing with a public health nurse who will make an initial assessment, educate and counsel about healthy behaviors in early pregnancy and refer women for appropriate services. Women who are at high-risk and income eligible at below 200 percent of poverty or eligible for Medical Assistance are enrolled in improved pregnancy outcome services. These services include public health nurse home visits which focus on assessment, monitoring, nutritional counseling, prenatal education, prevention of preterm birth education, case management and follow-up. Early identification of high-risk, low-income pregnant women will also be promoted at WIC clinics, medical clinics, schools, social services, migrant health services and other locations frequented by the area population.

CHB will make an effort to reach diverse populations. Print, videotapes, and other media material as well as clinical practices will be modified to meet the cultural expectations and language needs of the

populations in the service area. Workshops that address cultural health practices and beliefs will be made available to staff. Interpreter services will be available for home visits, community outreach and education. Activities at the local level will include enabling services such as provision of transportation, translation, outreach, health education, family support services, case management and coordination with WIC clinics.

The success of the activities described is contingent in part upon the continued effectiveness of improving rates of planned pregnancies and capacity to accommodate health insurance needs of the growing number of immigrants and refugees in a culturally acceptable manner.

NP #18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester

Title V activities which relate to this performance measure and priority need "Promote family support and healthy community conditions," Form 14, include community-based pregnancy testing and extensive support of enabling services. CHB will promote the initiation of prenatal care in the 1st trimester. Many will offer free pregnancy testing with a public health nurse who will make the initial assessment, educate and counsel about healthy behaviors in early pregnancy and refer women for appropriate services. Women whose pregnancy test is negative will also be counseled regarding family planning and healthy pre-pregnancy practices.

Outreach activities are fundamental to increase the number of women who will begin prenatal care in the 1st trimester. CHB staff throughout the state are skilled at initiating and maintaining collaborative relationships with other community organizations frequented by women of childbearing age. By reinforcing the importance of early pregnancy identification and referral as well as healthy life styles to community-based organizations and the women they serve, the opportunity for impacting attitudes and behavior is increased. CHB will promote such messages through collaborative agreements with area health clinics, hospitals, extension services, social services, schools, Headstart programs, and early child and family education programs.

Factors which could impact achievement of this performance measure include erosion of prenatal care as an insurance benefit and failure of the medical system to adopt to the cultural needs of an increasingly diverse population.

B. Children and Adolescents

SP #2 - The percentage of children and adolescents enrolled in health plans who receive comprehensive preventive health visits according to nationally accepted standards.

Title V activities which relate to this performance measure and priority need "Promote family support and healthy community conditions," Form 14, include support of the EPSDT program, funding for community-based services, and leadership to promote systems change.

Refer to the previous SP #2 narrative concerning Minnesota's EPSDT program, Child and Teen Check-Ups (C&TC), which provides comprehensive preventive health visits to the Medicaid population. The program provides a strong outreach component. Title V agency staff will enhance the outreach component of the C&TC program by providing technical support to local C&TC Outreach Coordinators, participating in regional C&TC outreach meetings sponsored by the Department of Human Services, and participating in health plan and county C&TC Outreach Coordinator sponsored regional meetings for clinic staff and providers.

Major obstacles to increasing the level of well-child visits and adolescent well-care visits would include erosion of employer-based insurance, especially non-ERISA employer insurance; lack of consensus over the periodicity and content of preventive well-child/adolescent care; data collection and publication issues; and affordability of insurance coverage.

C. Children with Special Health Care Needs

NP #3 - The percent of children with special health care needs in the state who have a "medical home."

Title V activities which relate to this performance measure and priority need "Increase percentage of children who receive early intervention services," Form 14, include improving access to a medical home through physician outreach and training; the development of materials in a variety of formats focused particularly on improving care coordination, cultural competence and family-centered care; and an ongoing commitment to local training and technical assistance for parents and professionals.

MCSHN applied for and received an MCH-B grant through which we are working with two Managed Care Organizations to first, identify CSHCN and to insure that children, once identified, have access to a medical home prepared to meet their needs. MCSHN clinics and Title V funds will be used to 1) support bringing a medical home tool kit for primary care providers ot the web and other formats and to keep that information current; and to 2) provide technical assistance to local health providers in rural Minnesota for medical home capacity building activities.

MCHSN will continue to sponsor and co-sponsor county and regional trainings for health care professionals and parents of children with special health care needs. One specific example is the "Taking

the Maze Out of Funding' training which assist communities in identifying available resources.

In previous years, access to a medical home was measured in terms of a child with special needs' visits to a primary care provider for a well-child check. If that was the only criteria for access to a medical home, Minnesota would be on target for achieving its original goal. This criteria is easily measured, but does not lend itself to substantive interpretation. MCSHN program activities will also continue to focus on 1) gathering data that more accurately reflects the "medical home" criteria defined by the American Academy of Pediatrics and 2) evaluating current resources and developing new resources to support a broader understanding of "medical home" on the part of physicians. Because of the change in how MCSHN measures access to a medical home, trends over time are not measurable.

Achieving this goal depends in large part upon the willingness of providers to change current practice and the extent to which our activities and those of our collaborators, such as the Minnesota Chapter of the AAP can influence that.

D. Enabling Services Affecting All MCH Populations

SP#8 - Percent of MCH plans that include objectives and methods to eliminate the disparity in health status between populations of color and the majority population.

Title V activities which relate to this performance measure and priority need "Promote family support and healthy community conditions," Form 14, include the MCH Special Projects grant program, funded with two-thirds of the federal MCH Block application supplemented with state funds. Also included are state technical support activities to reduce disparities.

All MCHSP applications address the issue of disparities among populations of color in their 2000-01 MCH grant applications; however applicants and reviewers noted a need to better address racial/ethnic data and disparity interventions. Given that one of the five Strategic Directions of the Department is elimination of disparities, this issue will be further addressed by various programs including Title V. Related to this, the state Title V program has applied to the CDC for a four year REACH (Racial and Ethnic Approaches to Community Health) intervention grant to address issues identified in the REACH first year planning phase (See Appendix T). The grant application proposes community-developed strategies to reduce disparities within the African American and American Indian communities in the counties of Hennepin (Minneapolis) and Ramsey (St. Paul).

POPULATION-BASED SERVICES

A. Pregnant Women and Infants

NP #4 - Percent of newborns in the state with at least one screening each of PKU, hypothyroidism, galactosemia, hemoglobinopathies

Title V activities which relate to this performance measure and priority need "Increase percent of children whose disability is identified early," Form 14, include leadership relative to conditions to be screened, community partnership, and follow-up of positive screens.

Relative to this performance measure, all newborns must be screened for the following disorders: phenylketonuria (PKU), congenital hypothyroidism, congenital adrenal hyperplasia, galactosemia and hemoglobinopathies. The Newborn Screening Program tests for these conditions and tracks the results of confirmatory testing of presumptive positive samples.

Plans for the Minnesota Newborn Screening Program for FFY 2001 include implementation of new technology in the newborn screening laboratory with the use of tandem mass spectrometry (TMS). Since additional newborn metabolic diseases will be detected, program efforts will be directed toward identifying which new conditions to add to the program, developing procedures for tracking and follow up of new conditions as well as education and collaboration with the medical community including primary and specialist providers and with families. Efforts will continue to provide technical assistance and consultation to public health and other community providers involved with newborn screening testing and follow-up. Outreach is being directed toward enhancing linkages with other statewide population-based programs such as newborn hearing screening, high-risk follow along programs and early childhood education. The newborn metabolic disease registry database of confirmed cases will complete the process of linkage to the Public Health Laboratory Division newborn screening database. The Newborn Screening Follow-Up Specialist will work with the Supervisor of the Newborn Screening Laboratory, the State Geneticist and others to identify strategies to improve access to comprehensive and appropriate specialized systems of care.

With the pending expansion of the Newborn Screening Program, many challenges are anticipated. These include the need for extensive program staff training both in laboratory and follow up activities; development and integration of testing and follow up policies and procedures into the present program; increased capacity and collaboration with pediatric metabolic medical treatment centers, significant statewide coordination and education with hospitals, physicians, others in the medical community and public health providers, and plans for evaluation of this new activity.

NP #5 - Percent of children through age 2 who have completed immunizations for Measles, Mumps,

Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B (Risk Factor)

Title V activities which relate to this performance measure and priority need "Promote family support and healthy community conditions," Form 14, include collaboration with immunization project staff concerning local integration of service components.

The Title V program is not the lead agency for immunization activities in Minnesota. Rather, the Acute Disease Prevention Services in the Disease Prevention and Control Division at the Minnesota Department of Health plans, implements and evaluates immunization activities. Title V staff collaborate in these activities.

Since 1988 the United States Public Health Service Immunization Practices Advisory Committee (ACIP) has recommended that all pregnant women be screened for hepatitis B surface antigen (HBsAg). The Minnesota Department of Health implemented a hepatitis B perinatal prevention program in 1990 with funding from the Centers for Disease Control and Prevention.

Changes to Minnesota's School Immunization Law will make hepatitis B shots a requirement for school enrollment starting with kindergartners in the 2000-01 school year. Grade seven will be added in school year 2001-02.

NP #9 - Percentage of mothers who breastfeed their infants at hospital discharge

Title V activities which relate to this performance measure and priority need "Promote family support and healthy community conditions," Form 14, include local counseling and state-level initial funding and continued participation in a program team.

Local public health staff (especially public health nurses) routinely advocate breastfeeding and include breastfeeding promotion strategies in contacts with families and community educational programs. State activities planned or continued during the 1999/2000 period include the "Loving Support Makes Breastfeeding Work" media campaign in Minnesota implemented by the Family Health Breastfeeding Team. The latest phase of the campaign uses four outdoor bulletins which will rotate through the 11 county metropolitan area for one year.

WIC staff will continue multiple activities to promote and support breastfeeding. The annual WIC Conference includes specific breastfeeding training sessions. The Native American population has been particularly targeted to increase breastfeeding numbers.

Although there appears to be continuing growth in public support for breastfeeding, other societal trends must be monitored for their potential to create new barriers, e.g. more rapid movement of low income new mothers into worksites where there may be barriers to breastfeeding.

NP #10 - Percentage of newborns who have been screened for hearing impairment before hospital discharge.

Title V activities which relate to this performance measurement and priority need "Increase percent of children whose disability is identified early," Form 14, include providing a lead role in the promotion and technical support of universal newborn hearing screening (UNHS) program development. Recently the MDH was awarded a four-year grant from MCHB to expand the voluntary UNHS program. Collaborative efforts are planned with Part C Coordinators and staff from the Departments of Health, Human Services and Education as well as the University of Minnesota Department of Otolaryngology. Major objectives of this grant project are to: screen 90% of newborns by Year 2004, establish an advisory committee, increase public awareness, offer education and training, and refine the tracking and follow-along system.

Since implementation of UNHS program is voluntary, hospitals may choose not to establish a program. If such hospitals have a large number of births, this could have a significant negative impact on reaching a 90 percent rate. However, if additional reimbursement for newborn hearing screening procedures is approved by health plans and the Department of Human Services, there could be a significant impetus to hospitals, health plans, providers and families for screening newborns.

SP #6 - Percent of women who use alcohol, tobacco or other drugs during pregnancy.

Related to this performance measure and priority need "Reduce drug, alcohol and tobacco use", Form 14, Title V provides staff expertise and support to a variety of team efforts. Minnesota has several initiatives to reduce the use of alcohol, tobacco and other drugs during pregnancy.

Fetal Alcohol Syndrome Program

The MDH team is working in four areas to address alcohol use during pregnancy and its affects on the fetus and newborn including research, a community grants program, professional education, and a media and public information campaign.

The research program involves developing an ongoing strategy by which the MDH can track the number of children in the state with conditions such as FAS and Alcohol Related Birth Effects (ARBE). This information will allow us to measure the effects of prevention efforts. A second component is a state-wide survey to determine physician's opinions, knowledge base, practices, and needs surrounding the issue

of FAS and ARBE. The information collected from this survey will help guide the design of professional education specific to ARBE and FAS. These two surveys, one to track incidence and prevalence of developmental delays and the second designed to assess primary care physician's needs, will be initiated in year 2000.

The community grants program involves 12 state-wide community-based agencies coordinating FAS prevention and intervention-oriented activities that respond to the needs of the local community. Prevention activities include media outreach, professional and community education, and strategies to enhance screening, counseling, referral, and follow-up for women who drink and children affected by prenatal exposure to alcohol. Intervention activities focus on expanding the services and networks for individuals and families coping with FAS or ARBE. MDH will sponsor its second annual FAS Summer Institute July 2000 for all community grantees. The program is designed to increase grant agencies' capacity to provide prevention and intervention services for women and children and to better evaluate those programs.

In collaboration with the Minnesota Board of Medical Practice, Minnesota Board of Nursing, universities, and other state agencies, the FAS Unit staff at MDH facilitate the development of professional training opportunities, curricula, and other materials addressing the needs of individuals with FAS or ARBE and the needs of pregnant women at risk for alcohol use during pregnancy. Recent activities include a self-learning packet for physicians and nurses. A video and leader guide for health and social service providers preparing them to screen women's alcohol use is available for distribution in summer 2000.

The media and public information campaign includes television and radio ads, brochures, and public restaurant posters targeted to women of child-bearing age, their friends and family, and the larger community. Select television and radio ads aired in 1999 will be broadcast again in 2000 and 2001. The campaign raises awareness about the effects of prenatal alcohol exposure. The materials promote the message, "Don't take the Risk, Don't take the Drink." Additional activities include distribution of educational videos, posters, and brochures through a state-wide network of health providers and social service agencies including local health departments. Plans for 2000 and 2001 include evaluating the recent media campaign, development and release of a multi-media campaign targeting racial and ethnic populations in Minnesota, creating fact sheets to replace brochures, and conducting two needs' assessments. One assessment will target professional education needs of health educators in local health departments, and the second will focus on women who have completed an alcohol recovery program to learn their perception of the program and services they received.

CISS Project

During the fourth and final year the project will focus on sustaining its work statewide, including useful tools and products continued through various systems through consultants provided with federal technical assistance, a review of the pre and post evaluation tools used in the demonstration sites, informational interviews of demonstration site community members and CISS project coordinator insights of overall project administration, community site implementation, and product development. The results of these reviews will be published and presented to at least four audiences—the local community public health organizations/coalitions, MDH administration, MCH Task Force, and the federal MCH Bureau. The intent is to provide a report and community-based tools for "Building Productive Community Connections."

Sustaining the efforts of this systems integration project is a major emphasis of the remaining months. The intent is to integrate the system integration principles (principles for blending community systems) into existing projects and programs.

The project products that will be made available are:

- "Promising Practices: Guidelines for Alcohol and Tobacco Screening, Brief Intervention , Referral and Follow-up Activities Among Youth"—address individual and community-level approaches to create communities free of alcohol and tobacco use by its youth. (This includes pregnant youth)
- Community Planning Tools for Building Productive Community Connections—currently adapted for Tobacco Prevention, Community Cessation Programs, Alcohol Messages Campaign (Because It Matters). The Tobacco adaptation is available on the internet at www. health.state.mn.us/topics, click on tobacco prevention. (These tools include the Community-based Prevention Wheel for identifying community partners).
- MDH-CISS Project Report—This report will contain the results of several evaluation activities and lessons learned for community development activities and Statewide project coordination.

Collaboration with Tobacco Control Program

Within the Bureau of Family and Community Health, the MCH staff work collaboratively with the Tobacco Control Program staff. Staff met periodically to discuss the issues of tobacco use among women, including pregnant women and the effects of tobacco use on women's health, pregnancy, and birth

outcomes. The recommendations from MCH's Ad Hoc Committee on Fetal & Infant Mortality Reduction included reducing tobacco use by pregnant women and exposure to environmental tobacco smoke, and increasing smoke-free childcare environments. These recommendations fit the Department's Strategic Direction to reduce tobacco use and improve the health of Minnesota's youth. MCH staff are working with the American Cancer Society and local public health agencies to implement the Make Yours a Fresh Start Family, an evidence based smoking cessation intervention program.

Child & Teen Check-Up Activities

The C&TC staff will continue to provide Child and Teen Checkup training sessions with instruction on health history questions specifically regarding alcohol, tobacco and other drug use during pregnancy.

Successful reduction of alcohol, tobacco and other drug use during pregnancy requires strategies aimed at strengthening society norms and changing personal behavior. Erosion of health insurance coverage of tobacco cessation programs and/or chemical dependency assessment and treatment will negatively affect ability to achieve this goal. If funds currently supporting media and educational messages around responsible use of alcohol, tobacco and other drugs are curtailed or fall subject to economic changes, the impact on influencing cultural norms could affect our ability to achieve our goal.

B. Children and Adolescents

NP #5 - Percent of children through age 2 who have completed immunizations for measles, mumps, rubella, polio, diptheria, tetanus, pertussis, haemophilus influenza, hepatitis B.

Title V activities which relate to this performance measure and priority need "Promote family support and healthy community conditions," Form 14, include collaboration with immunization project staff concerning local integration of service components.

The federally-funded Vaccines for Children (VFC) program began on October 1, 1994, with a goal of ensuring affordable vaccines for all children. The Acute Disease Prevention Services Section of the Disease Prevention and Control Division has developed an enhanced version of the program which is called "MnVFC". The MnVFC program utilizes federal VFC funding to supply vaccine at no cost to participating providers to be administered to uninsured children and also utilizes federal 317 funding to provide vaccines to children whose insurance requires deductibles and/or co-pays for immunizations as well as vaccine for in-school clinics.

Minnesota legislation requires that all clinics that serve clients under a Minnesota Health Care Program (MHCP) such as Medical Assistance, MinnesotaCare, or General Assistance Medical Care be

enrolled in the MnVFC program.

The Title V program is not the lead agency for immunization activities in Minnesota. Rather, the Acute Disease Prevention Services Section in the Disease Prevention and Control Division plans, implements and evaluates immunization activities. In collaboration with the Acute Disease Prevention Services staff , Title V staff provide immunization training sessions to public and private providers through Child and Teen Checkups training.

NP #6 - The rate of births (per 1,000) for teenagers aged 15 through 17 years (Risk Factor)

Related to this performance measure and priority need "Reduce teen pregnancy and teen birth rate," Form 14, the Title V program is conducting a number of activities through state staff and local grantees to reduce the state's teen birth rate.

Family Planning

Title V and State FPSP grant recipients will conduct public information campaigns to increase the awareness of family planning services in their geographic area. Public information campaigns can include newspaper articles, billboards, cable TV shows and radio talk shows. The state-wide hotline provides information and referral services as well as media campaigns to increase the awareness of family planning services in the state. The media campaigns include radio spots, billboards, posters and other novelty items such as pens and key chains. Title V and state FPSP grantees will also continue to provide individual education and counseling.

Technical assistance will be provided to FPSP grant recipients as identified through contacts with them, i.e. phone conversations. Workshops will be offered to grant recipients and other family planning providers as requested.

Minnesota ENABL Program

About twenty eight communities will plan and implement community organization strategies by collaborating with other community groups and interested persons to provide school and community wide activities, to convey and reinforce the MN ENABL (Education Now and Babies Later) message. Direct youth education using the "Postponing Sexual Involvement" curriculum will also be implemented. Some MN ENABL projects will use older students (teen leaders) who are trained in teaching the PSI curriculum and assist the adult leaders in presenting the information to the younger students. Television and radio ads,

bill boards, and mall kiosks along with additional promotional items will be developed and utilized throughout Minnesota. This campaign will support activities occurring in funded communities. Training and technical assistance will be provided by the Minnesota Department of Health. These activities will be developed based on the needs of the funded communities. An evaluation of state and local MN ENABL activities will also be conducted.

Abstinence Education

Fourteen Minnesota Abstinence Education grantees will reach about 4,000 youth, ages 14 and under, with a state-approved curriculum in 2001. Grantees will also convey the program message by implementing community organizing activities through collaborations with other community groups. These community organizing efforts target youth and their parents/caregivers. The curriculum and community organizing efforts will be supported and reinforced by a state-wide media campaign. State and local activities of the Minnesota Abstinence Education community grant program will continue to be evaluated. The MDH provides training and technical assistance to grantees throughout the year.

African American Teen Pregnancy Initiative

The Office of Minority Health, serving as the convener, is in the process of developing a collaborative of community-based organizations and the St Paul and Minneapolis School Districts to develop policies and programmatic efforts focusing on African American teen pregnancy prevention to reduce the current disparity. The Title V program will be an active collaborator in this regard. The collaborative is composed of 55 individuals that represent social service, school systems, public health, faith communities, health systems, private sector, community organizations, youth, and community members. The mission is to reduce the teen pregnancy rate for African American teens in Minnesota. The collaborative began in December of 1999, and presently is composed of four working groups with each focusing on one of the following goals: expanding public awareness and mobilization, promoting pregnancy prevention efforts in institutions, organizations and agencies, promoting pregnancy programs and services that are culturally specific to African American teens and monitoring and advocating for changes in policies that will increase resources for effective intervention/prevention programs. The first African American Teen Pregnancy Prevention Rally convened in April 2000 to mark the beginning of the partnership with the African American Teen Pregnancy Prevention Collaborative.

MN Sexuality Education Resource Review Panel

The MN Sexuality Education Resource Review Panel is a collaborative effort of public and private agencies coordinated by the MN Organization on Adolescent Pregnancy, Prevention and

Parenting. The MDH will continue as an active member of this panel, which works to critically review and recommend effective sexuality curricula / resources for use in schools and communities.

Case Management Services For Pregnant & Parenting Teens

Using Title V grant funds, the Minneapolis Department of Health and Family Support will continue to support case management services to pregnant and parenting teens and their children in collaboration with the Minneapolis Public School District. The goal of this program is to reduce teen pregnancies and ensure school completion.

Tobacco Settlement

As part of the Minnesota tobacco settlement funds have been allocated for statewide distribution to address risk taking behavior in youth. Title V staff will be an active part of the Adolescent Health Team established to guide implementation of this new program.

Progress toward achievement of the performance objective may be enhanced by the new youth risk behavior initiative described elsewhere. One of the six targeted behaviors for which funds can be used is sexual behaviors that may result in pregnancy, HIV or STD's. It is anticipated that some local agencies will choose to target funds toward reducing this youth risk behavior.

NP #7 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

Relative to this performance measure and priority "Promote family support and healthy community conditions," Form 14, Title V collaborates with activities of the Division's Dental Health Program concerning child health policy, coordination of state technical support services and fiscal support of local programs.

The C&TC staff will continue to provide Child and Teen Checkup training sessions which include discussion of dental sealants and dental screening.

In Hennepin County funding will be provided to Children's Dental Services in order to provide dental health services including sealants to targeted child and adolescent population.

There is a need to better understand the factors which contribute to the gap between performance objectives and performance accomplishments.

NP #8 - The rate of deaths to children 1-14 caused by motor vehicle crashes per 100,000 children.

Related to this performance measure and priority "Promote family support and healthy community conditions," Form 14, the Title V program supports local purchase of equipment and program activities and collaborates with the state injury control program staff.

It is anticipated that additional car seats will be distributed to those who need them; that increased focus will be placed on adult women, teens and children being properly restrained in a motor vehicle; and that legislative discussion will again occur regarding passage of a seat belt primary offense law in Minnesota.

The C&TC program will continue to provide Child and Teen Checkup training sessions which include anticipatory guidance on safety issues including car seats and seat belt use.

We should continue to see a reduction in crash death rates to the extent that health professionals continue advocating for motor vehicle safety instruction as a viable aspect of their daily responsibilities. Correct restraint needs to be modeled by parents and care givers, queried and taught by health professionals, and car / booster seats need to be provided to those who otherwise would not be able to afford them. However, public health staff are being asked to address a wide range of health risks and behavior and motor vehicle-related injury / death is sometimes accepted as unavoidable or is viewed as non-preventable. This confounds achievement of this performance objective.

The Minnesota Legislature could strengthen enforcement of laws related to seat restraints, alcohol use by vehicle operators (including lowering our DUI limit to 0.08), speed violations, and nocturnal teenage driving. Action in any of these directions would improve the health outcomes of Minnesota's children. It does not appear likely, however, that the current climate favors such legislative action.

Continued improvements in Minnesota's EMS and trauma care systems will reduce the risk of death post-crash. The corollary is that Minnesotans are driving more, thus increasing exposure to and risk of motor vehicle crash injury and / or death.

SP #4 - Incidence of substantiated child maltreatment by persons responsible for a child's care.

Title V activities which relate to this performance measure and priority "Reduce child abuse and neglect" and "Address the multi-faceted needs of teen parents," Form 14, include funding of local home

visiting programs and state program administrative and technical support.

Home Visiting Programs for Prevention of Child Maltreatment

Established in 1992, the targeted Home Visiting Program to Prevent Child Abuse and Neglect provides grants, training, and consultation to assist local public health agencies to expand existing public health nurse home visiting services targeting at-risk families. Grant awards also assist local public health agencies to develop a coordinated, community-based approach to the prevention of child maltreatment. Two new programs will be funded in 2001. A program evaluation report will be available in the summer, 2000.

The Minnesota Healthy Beginnings (MHB) program, established in 1997, is a universally-offered home visiting program for expectant parents and those with new babies. In 1999, the program awarded five-year grants to four local public health agencies. The MHB program provides a public health nurse assessment during the first home visit and ongoing visits providing information, support and linkages to community resources based on family interests and needs. Families identified at-risk for child abuse and neglect are identified and referred to targeted program services.

During its 2000 session the Minnesota legislature appropriated TANF money ($21 million), for distribution by the MDH, to be used by local public health agencies for provision of home visiting services to families at or below 200 percent of the poverty level. Funding is for 3 years at $7 million/year. The MDH will provide technical assistance, training, and evaluation as described in the MHB program statutes.

NCAST / HOME Training

Staff will continue to provide H.O.M.E (Home Observation for the Measurement of the Environment) and Nursing Child Assessment Satellite Training Sessions (NCAST) to community MCH public health nurses. The H.O.M.E scale is to assess the amount of nurturance and stimulation provided to a child. The NCAST scales are used to assess parent-child interaction during feeding and teaching events. It is a valid and reliable approach, recognized by the legal system in dealing with child abuse or neglect cases.

Home visiting by public health nurses or other home visitors is an important tool for achievement of reducing the incidence of child maltreatment. Its success will largely be determined by continuation of adequate funding.

SP # 9 - Proposed New State Performance Measure Related to Youth Risk Behavior Reduction

Related to the needs assessment priority "Reduce youth risk behaviors" a new state performance measure will be developed for inclusion in the FFY 2002 application. The Youth Risk Behavior Endowment is a new Minnesota Department of Health initiative that will give local public health agencies an opportunity to address a broad range of youth risk behaviors and the risk and protective factors that influence these behaviors. The targeted risk behaviors include alcohol and other drug use; sexual behaviors that may result in pregnancy, HIV and STDs; violence; suicide; physical inactivity; and unhealthy dietary behaviors. Funding for this initiative is provided through the Tobacco Prevention and Local Public Health Endowment established during the 1999 legislative session. Funding will be provided to all Community Health Service agencies through non-competitive grants. Funding for the first year (July 1, 2000 - June 30, 2001) will be $2.0 million growing to approximately $5 million in 2003.

In the upcoming year, the focus of the program will be local implementation of both risk reduction and healthy youth development strategies related to the six identified risk behaviors. The program will build on what already exists in the community using evidence-based or promising practices. Local programs will be encouraged to plan for and implement strategies addressing more than one intervention level (individual, community, systems), working with multiple community partners including youth.

C. Children with Special Health Needs

The national and state performance measures do not include a population based measure specific to children with special needs. However, MCSHN does provide several population based services for the CSHCN population and their families. This includes workshops to explain health care insurance and funding options to families; family information packages that provide information on defining CSHCN, family-centered care and issues in managed care; and workshops for providers.

D. Population-Based Services Affecting All MCH Populations

SP# 3 Incidence of injury (fatal-non-fatal; violence/unintended) among all MCH populations.

Relative to this performance measure and priority need "Promote family support and healthy community conditions," Form 14, the Title V program collaborates with the Division's Injury Control Program Unit and provides funds for community-based services through the Maternal and Child Health Special Project grants.

Unintentional Injury

Injury unit staff promote the use of bicycle helmets, seat belts, smoke alarms, and the Home Safety Checklist, in particular among families with young children. Efforts to prevent traumatic brain injury will also continue. MCH Special Projects funds will continue to support childhood injury control activities of Community Health Boards.

Violent Injury

Staff are currently seeking funding to continue community-based training of health professionals on skills related to the analysis of local data, assessment of community needs and the implementation and evaluation of control and prevention programs. The Sexual Violence Prevention Program will continue to offer training and advocacy support, as well as distribute prevention materials across Minnesota.

The priorities of the current administration (Governor and Legislature) can affect the degree to which communities are able to institutionalize or even respond to injury and violence prevention as local public health priorities. For example, important principles of the Governor are self-sufficiency and personal responsibility. Aspects of those principles can coincide with or contradict policies and programs that could reduce risk of injury and violence. In addition, the tenant of honoring local decision-making can mean that the community may select, in the short term, public health priorities other than those relating to injury and violence prevention. To support local decision-making, however, the MDH recently published county level injury and violence data, which should help to buttress the development of local policies and programs relating to injury and violence prevention.

INFRASTRUCTURE BUILDING SERVICES

A. Pregnant Women and Infants

NP #15 - Percent of very low birth weight live births.

Relative to this performance measure and priority need "Promote family support and healthy community conditions," Form 14, Title V funds support the local public health infrastructure and the state program is actively collaborating with others to reduce disparities.

Community Health Boards and the MDH plan to continue activities previously described in the annual report component of this document, to decrease the percent of very low birth weight births and improve the numbers of women who begin prenatal care in the first trimester. Large disparities exist between racial groups in Minnesota related to the percentage of very low birth weight births and the percentage of infants born to women who initiated prenatal care in the first trimester. It remains a priority

goal to reduce these disparities.

The Division of Family Health and the Office of Minority Health in the Minnesota Department of Health successfully partnered with community based service agencies in the African American and American Indian communities to secure a CDC REACH (Racial and Ethnic Approaches to Community Health) Project, planning grant. The primary goal of the REACH Project is to eliminate the infant mortality disparity among the African American and American Indian populations relative to the white population in Ramsey and Hennepin Counties. Community-developed strategies have been identified to reduce the incidence of low birth weight and improve the numbers of women initiating early prenatal care. An application for four years of implementation funding was submitted to CDC in July, 2000. (See Appendix T. REACH application, for data analysis and proposed strategies.) Further information on partnerships to eliminate infant mortality disparities is contained in the report component of this application which describes the relationship of Twin Cities Healthy Start projects and MDH Title V activities including the REACH project.

State infant mortality reduction funding for 2000 - 2001 will be used for a two phase qualitative research project to identify factors that contribute to the disparities in pregnancy and infant outcomes experienced by American Indian and African American families in Minnesota. Phase I will be conducted in collaboration with the eleven Minnesota Indian Reservations. Information will be gathered from families who have recently given birth. Questions will center around a variety of topics from cultural practices to health behaviors, and will cover access and barriers to perinatal care. Summary reports and recommendations will be developed with each tribal community to be used to guide state level and tribal activities.

Phase II's qualitative research will focus on American Indian and African American families in the Minneapolis and St. Paul metropolitan area. This research will be coordinated with the activities of the CDC-funded REACH Project. Concentrations of infant mortality have been identified in four areas of Minneapolis and two areas of St. Paul. It is planned that community-based organizations serving families from those six communities will be approached to collaborate and recruit participants. Summary reports and recommendations will be developed and will be used to guide and enhance other infant mortality reduction efforts.

Barriers to early and appropriate prenatal care and inadequate commitment of resources for primary prevention activities will impede progress toward this performance objective.

NP #17 - Percent of very low birth weight infants delivered at facilities for high risk deliveries and neonates.

Title V collaborates with other organizations to address the issue of this performance measure and priority need "Increase percent of children who receive early intervention services," Form 14. The Minnesota Perinatal Organization (MPO) and the Minnesota March of Dimes (MOD) are examples of two organizations whose purposes focus on healthy pregnancy outcomes. The MCH staff will continue to be actively involved with both groups in program planning for health professionals. The MPO targets all health professions involved in perinatal care in providing educational conferences to improve the health care of pregnant women and newborn infants. As a member of the Great Plains Perinatal Organization, MPO has been instrumental in improving perinatal health care within the six state region through the development of a regionalized system of perinatal health care services. The MOD focuses on both consumer and professional education.

An obstacle to achieving positive movement towards this objective lies in system resistance to designation and expected utilization of regional high risk care centers.

NP #18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

Relative to this performance measure and priority need "Promote family support and healthy community conditions," Form 14, Title V staff collaborate with many state and community partners to address systems barriers.

Title V staff will continue to work with public health agencies, area representatives in managed care, and local providers to create a comprehensive, population-based model of prenatal care. Within this model, early identification and initiation of prenatal care is emphasized. Populations within the geographic district who have the lowest rate of initiation of early prenatal care will be targeted to improve those rates. Examples of initiatives to improve the numbers of women who initiate early prenatal care include the REACH Project, and Twin Cities Healthy Start Project, Healthy Communities (3 counties in central Minnesota) and Integratcd Prenatal Care Model (10 counties in west central Minnesota). Activities cited previously under NP #15 in the Infrastructure Building Services component of the plan also include strategies to improve the number of women who begin prenatal care in the first trimester. Activities described under NP #18 in the Enabling Services component of this plan also include strategies for early

prenatal care.

Achievement of this performance objective is contingent in part on improving rates of planned pregnancies and assuring universal culturally sensitive access to care.

B. Children and Adolescents

NP #16 - Rate (per 100,000) of suicide deaths among youths aged 15-19

Title V activities which relate to this performance measure and priority need "Improve mental health of children, youth, and parents," Form 14, include close collaboration with the Division's Suicide Prevention Initiative, and leadership and collaboration with many partners concerning adolescent health, social emotional health, and school health.

Suicide Prevention Initiative

At the direction of the 1999 Minnesota Legislature (Ch. 245, Article 1, Section 3),the Minnesota Department of Health (MDH) conducted a study of suicide in Minnesota and, in consultation with a large group of stakeholders, developed a statewide suicide prevention plan. The plan includes recommendations from the Commissioner of Health and suggested strategies from an ad hoc advisory group. The report is the first step in implementing a comprehensive suicide plan across multiple organizations in the public and private sectors. The ad hoc advisory group will continue to work with MDH to implement recommendations from the report and develop both policy and funding recommendations for consideration by state agencies, the legislature, and private sector and non-profit partners who have a role in suicide prevention.

Adolescent Health Promotion

The MDH will continue efforts to develop a "*MN Adolescent Health Action Plan"* based on a healthy youth development framework. This project is a collaborative effort with the University of Minnesota and community partners from throughout the state (including adolescents). This project includes development of a framework, evaluation of adolescent health data, development of recommendations for action, examples of promising strategies, identification of resources to support the action steps, and engagement of key stakeholders in implementing the action steps.

The MN Alliance with Youth is another broad community collaborative in which the MN Department of Health will continue to play a critical role. The goal of this "movement" is to help local

communities promote healthy children and youth through a healthy youth development model. Activities will include training on youth development and community collaboration, technical assistance to support local community efforts and public awareness campaigns to engage people in the project.

Social Emotional Health Promotion

A focal point for Title V capacity has been a five year SPRANS mental health grant which ends September 30, 2000. "Lessons learned" during this project will be integrated into other department activities and staff continue to refine the mental health promotion strategies created and documented in MN Public Health Goals 2004. A compendium of all mental health requests by local public health agencies across the state will be completed by May 2000, in conjunction with spring regional meetings of local CHS agencies. There is an intra-agency "mental health interest group" which continues to meet with the intent to create a statewide public health framework for mental health as a basis for future social/emotional health initiatives.

Child & Teen Check-Ups

The C&TC staff will provide Child and Teen Checkup Training sessions which include information and resources on mental health screening and referral.

School Health Consultation

The MDH will continue it's provision of technical consultation to school administrators, school nurses, parents and advocates related to maintaining the health and safety of students in the states public, private and charter schools. This consultation is enhanced through the preparation and dissemination of information in the newsletter "Healthy Children Healthy Schools" and the updating of chapters in the Minnesota School Health Guide. School based unlicensed assistive personnel training activities will continue in conjunction with the Minnesota Department of Children, Families and Learning, the University of Minnesota Office of Community Integration, Minnesota school nurses, and the Minnesota Technical College system. MDH will be working in a collaborative effort with the Minnesota Board of Nursing and the School Nurse Organization of Minnesota to examine professional practice and student safety issues related to the administration of medication, particularly over the counter medications, in Minnesota schools.

NP #12 - The percent of children without health insurance.

Title V activities which relate to this performance measure and priority need "Promote family support and healthy community conditions," Form 14, include partnership with other entities committed to the objectives of universal access through system reform and better client utilization of government programs such as Medical Assistance.

The Minnesota Department of Human Services (DHS) is the state Title XIX agency, the state agency that administers MinnesotaCare, and the designated Title XXI agency. Working relationships between the Title V program and DHS have been described elsewhere in this application and will be used wherever possible to influence policy decisions in the implementation of the S-CHIP program and the outreach activities of both the MinnesotaCare and Medical Assistance programs. In addition, Title V program staff will collaborate with the state affiliate of the Children's Defense Fund in the CDF campaign (*Covering Kids)* to decrease the number of uninsured children in the state.

As mentioned in the priorities/initiatives component of the state overview section, there is a gubernatorial-directed, statewide initiative including a number of elements, one of which revolves around the issue of self-sufficiency. Health reform is included within the self-sufficiency area and a major focus of time and other resources will be on achieving the goal of insuring all children in the state. The major strategic approach to accomplish this will be to utilize the existing MinnesotaCare program in combination with the federal S-CHIP program.

The tactics will be the elements of a recently submitted 1115 waiver request including, for example, presumptive eligibility for children under 19 who apply for MA or MinnesotaCare. Analysis of the state-specific Minnesota Health Access Survey, 1999 by MDH staff revealed that 70 percent of the state's uninsured children met the income standards for MinnesotaCare. This initiative will be led by the Minnesota Department of Human Services because it is the designated Title XXI state agency, but MDH will be actively involved and Title V staff will be a primary resource for the department in this effort.

Major events that would negatively impact on the objective of this performance measure include erosion of employer-based insurance, economic recession or denial of the state's request for an 115 waiver relative to the proposed Title XXI program.

NP #13 - Percent of potentially Medicaid-eligible children with a service paid by the Medicaid program.

Relative to this performance measure and priority need "Promote family support and healty community conditions," Form 14, the Title V programs work collaboratively with the state Title XIX

agency on access issues and provide support to local programs concerning outreach services.

Title V agency staff will enhance the outreach component of the C&TC program by providing technical support to local C&TC Outreach Coordinators, participating in regional C&TC outreach meetings sponsored by the Department of Human Services, and participating in health plan and county C&TC Outreach Coordinator sponsored regional meetings for clinic staff and providers.

MCSHN will continue to conduct outreach activities through a number of outlets. Community Systems and Development staff are active in providing information on the Medicaid Program through clinics and inservices to community members, both families and professionals. The MCSHN information and referral (I&R) line will continue to provide information about medical funding sources, including Medicaid; and will send out Medicaid applications to potentially eligible families who call the I&R line. In addition, MCSHN will continue to send out letters to families with children applying for SSI benefits (when they are found either medically allowed or denied), encouraging application to Medicaid. MCSHN is also currently working on developing Medicaid letters to go out to those families with children already on SSI that are being re-reviewed, when their SSI eligibility is found to be continuing or ceased.

MCSHN will continue to work with partners to reduce barriers to service. A topic of particular current interest is third party funding for IEP/IFSP health related services. As a result of federal IDEA regulations and 1998/1999 changes to Minnesota statues, school districts are required to seek reimbursement from third party payers including MA beginning July 1, 2000. Minnesota legislation enacted in 1998 directed a simplified process for schools to access MA funds. MCSHN staff participate in monthly meetings with the Department of Human Services (MA), Department of Children Families and Learning (Education), to develop this simplified process and plan for the implementation as well as to clarify and interpret barriers. An extensive “Mapping Project” is in process to identify the IEP services and service providers eligible for MA reimbursement. Future activities include completion of the Mapping Project, development: of a cost based interim rate reimbursement, an informed parental informed consent, a data collection and management system, training and technical assistance, guidelines and materials, an interagency agreement. and establishment of a monitoring and compliance system.

Lack of access to and availability of culturally appropriate services would negatively impact children receiving care. Continued work by the DHS to streamline applications for financial assistance facilitates outreach activities. An increase or decrease in reimbursement for services (e.g., dental exams, newborn hearing screening) could impact the percent of children receiving services positively or negatively respectively.

C. Children with Special Health Care Needs

SP #1 - Number of local public health agencies which track children with identified risk factors which may lead to chronic illness

Relative to this performance measure and priority need "Increase percent of children who receive early intervention services," Title V is actively involved in the Follow Along Program (FAP). The FAP is Minnesota's tracking system for children with identified risk factors which may lead to chronic illness/disability.

The Minnesota Department of Health -Title V program is actively involved in population based public health Early Childhood Tracking through the Follow Along Program (FAP). Early Childhood Tracking is defined as the "periodic monitoring and assessment of infants and toddlers at risk for health and developmental problems to ensure early identification, help, and services. The goal of a statewide Early Childhood Tracking system was enhanced with one time Part C grants to local public health agencies to initiate or expand FAP. As a result of the grant, technical support and training, 81 counties are now enrolling children and 3 are in the planning stages. Agencies will be developing plans to continue the FAP one year beyond the grant. Participating agencies have access to new software to assist in the ongoing tracking of children and data collection. Technical assistance will continue to be provided to participating counties to support their activities, provide training and provide regional and statewide data for comparison to their local data.. The FAP will be exploring ways to evaluate the impact of the program, over the next three years.

Conflicting priorities at the local public health agencies or loss of funding may affect achievement of this objective.

NP #11 - The percent of children with special health care needs in the MCSHN program with a source of insurance for primary and specialty care.

Relative to this performance measure and priority need "Promote family support and healthy community conditions," Form 14, The Title V program advocates for needed resources and utilizes some of its funds as needed to close the gaps.

This year there was an increase in the number of children on the MCSHN program who are uninsured. The uninsured rate had been steady at about 20% for years and now it is at an average of 23% with a breakdown showing that 30% of the lower income families are uninsured. MCSHN plans to monitor this closely to see if this is a trend and has begun plans to pursue more complete insurance

information through the ongoing needs assessment process. Additional information is needed concerning the uninsured families. Are they working for employers who do not offer dependent coverage, is the dependent coverage too expensive, and/or is the benefit package not adequate for the needs of the child and therefore not considered worth the premium costs? These questions will be pursued over this coming year.

MCSHN may not be able to impact the number of uninsured CSHCN over this next year. Our goal is to monitor the trend and determine it's causes. If we are able to modify our needs assessment tool over this next year we will have new information from families regarding their uninsured status.

NP #14 - The degree to which the state assures the family participation in program and policy activities in MCSHN Program.

Title V activities which relate to this performance measure and priority need "Promote family support and healthy community conditions," Form 14, include recruitment, hiring and training of six parents to serve as family consultants.

MCSHN plans to expand the role of families in program and policy activities to acknowledge and encourage the unique contributions that families can make to the program. A hired parent consultant will continue to prepare a plan for the development of a Family and Community Advisory Committee for MCSHN. This advisory committee will provide ready and consistent access to ideas, advice and information from families in particular and also from the broader community of providers and systems within which children with special health needs and their families live, and assist MCSHN in its goal of ensuring systems and services are family-centered, community-based, comprehensive and culturally sensitive. This would ensure that family-centered care is more than just a philosophy because parent members monitor and suggest adjustments so that elements of family-centered care are actually practiced in programs and services provided to children with special needs. A primary benefit to MCSHN in establishing an advisory committee is to create a formal and public way of processing issues and information. The goal will be to make programs more consumer friendly and provide collaboration between state, families and providers.

MCSHN has contracted with an external Parent Consultant to assist over this next year in moving ahead in the process of having stronger parent involvement. Initially, six parents are to be recruited and provided training and orientation to their role as Family Consultants within MCSHN. The Family Consultants will be asked to self identify their desire to work on time limited tasks. There will also be a formal training for both the Family Consultants and MCSHN staff regarding working effectively together and to assist all in the practice of negotiation skills and collaborative problem-solving techniques.

It is hoped that this year nothing will forestall plans to have Family Consultants hired, trained, and functioning in an advisory role. However, as MCSHN experienced delays related to the absence of a section manager this past year it must also face the fact that there could be further delays in implementation due to the hiring of a new manager. However, the existence of a contract with an external provider to recruit parents as well as plans in place for parents to provide inservice training to MCSHN staff should assure reaching the performance objective.

D. Infrastructure Building Activities Affecting All MCH Populations

SP #7 - The number of counties with a Children's Mental Health or Family Service Collaborative.

Relative to this performance measure and priority need "Improve mental health of children, youth and parents," Form 14, the Title V program provides staff participation in state administrative and support teams and technical assistance to local programs to assure an effective public health component.

Technical support to the local children's mental health and family service collaboratives is coordinated through interdisciplinary focus teams comprised of state and community level staff. Integrated service delivery systems, governance, information systems and evaluation, and integrated financing are among the broad topic areas addressed by the focus teams. The state public health system is represented by Title V staff working on the topics of children with special health needs, and public health nursing. At the local level, CHB staff are often partners in these collaboratives and find the collaborative goals, objectives, and integrated services delivery venues (one-stop shopping) appropriate to their MCH-related goals, objectives, and activities. These staff also contribute their MCH health-related expertise to the collaborative technical assistance delivery system in the state.

Recent legislation allowing school districts to bill directly for services provided to disabled children may impact the development of collaboratives in counties without existing collaborative structures. The legislation allows counties and school districts to enter into agreements or negotiated arrangements to provide mental health services to children without involving the other partners as specified in the Children Mental Health Collaborative enabling legislation. Through technical assistance to local collaboratives and participation in the planning and implementation of the school billing legislation, MCH will advocate the broader involvement of agencies and community organizations in the collaborative efforts under either system.

4.2 OTHER PROGRAM ACTIVITIES

A. Toll-free Telephone Number

For parents and others, the Minnesota Title V programs assure toll-free telephone access to information about health care providers and practitioners who provide health care services under Titles V and XIX SSA and about other relevant health and health-related providers and practitioners. MDH has worked to accomplish the intent of this requirement by improving the effectiveness of previously established special purpose toll-free arrangements.

1. Title V (MCSHN)

MCSHN has operated a toll-free Information and Referral telephone line since March of 1990. The toll-free number is 800 728-5420. This line offers a comprehensive listing of services provided by state and county health and human services departments, hospitals, associations, family support groups and allied public and private entities. This listing is for families, teachers, nurses, social workers and anyone who needs assistance in locating resources for children with special health needs. The toll-free number is included on all educational and informational publications developed and distributed by MCSHN and is included in all media announcements pertaining to MCSHN clinics. The line handles nearly 5,000 calls per year.

2. Family Planning

The state Family Planning hotline is funded through state appropriations for the Family Planning Special Project (FPSP) grant program. The hotline is staffed by individuals trained in family planning counseling as well as information and referral. The number is 800-78-FACTS. In 1999, approximately 6,087 calls were handled by the hotline. During CY 2001, the hotline will continue to promote its availability statewide. All family planning related educational materials distributed by the Minnesota Department of Health include the hotline number. Annually, a pamphlet about family planning, which includes the hotline number, is mailed to all Medicaid recipients.

3. Prenatal Care

Minnesota does not have a dedicated 800 number for questions related to prenatal care or pregnancy. The Department of Human Services (DHS) consumer services call center handles questions related to obtaining prenatal care services from Medical Assistance or MinnesotaCare. Staff answering the phone direct questions to appropriate resources in DHS and/or to their county public health agency or the Division of Family Health at the Minnesota Department of Health.

Information regarding obtaining prenatal services and related questions can also be accessed via

the MDH or DHS internet web sites.

4. WIC

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) 800 number is funded through the Minnesota WIC grant and provides 24 hour - 365 days a year phone coverage. Callers to the WIC 800 number are provided with the business telephone number of the WIC Program in their geographic area. Callers who would like additional information about the WIC Program are given the number of the state WIC office. The toll-free number is 800-WIC-4030. The service responds to approximately 900 calls per year. All WIC brochures and educational materials distributed by the state WIC office and the local projects include the 800 number.

5. MinnesotaCare

The MinnesotaCare program provides an automated state toll-free line that operates 24 hours a day, seven days a week. The automated message is available in Spanish, Hmong, and Somali. The number is 297-3862 (metro) and 1-800-657-3672 (greater Minnesota). The toll-free number will provide the caller with general information about the plan, qualifications for acceptance, and application information. All outreach materials distributed by the Department of Human Services include this state toll-free number for clients to call with questions. The lines handle about 200,000 calls per year.

6. Minnesota Immunization Hotline

The Minnesota Immunization Hotline was established in 1994 and operates between the hours of 8:00 a.m. - 4:30 p.m. Monday through Friday. The Hotline is staffed by a team of nurses and other professionals highly-trained in immunizations. Its primary purpose is to provide a timely source of information and consultation for providers and consumers faced with the increasing complexities of immunizations. In 1999 the Hotline received 3,274 calls primarily from health care providers. Staff have anecdotally indicated the increase in complexity of calls addressing the School Immunization Law, new vaccines, changes in immunization practice recommendations, inappropriate administration techniques and media stories (e.g. bioterrorism, vaccine-preventable disease outbreaks and influenza season). In addition to consultation, callers can request print materials or information regarding Centers for Disease Control and Prevention teleconference training programs. To promote the Hotline as a service to providers and consumers, the Hotline phone number has been included on all immunization print materials developed by MDH and added to all media campaign PSAs and radio spots.

B. Titles V-XIX Coordination

The MDH assures that the Minnesota Title V programs will participate in the arrangement and carrying out of coordination agreements with the Title XIX program administered by the Minnesota Department of Human Services. As evident throughout the application, the extent of collaboration between the Medicaid program and the Title V programs in Minnesota is considerable. The formal interagency agreement between the agencies has been designed to facilitate response to the rapidly changing health care services and delivery system in Minnesota. (See Appendix I. STATE OF MINNESOTA INTERAGENCY MEMORANDUM OF UNDERSTANDING). Managers responsible for children's programs at the Minnesota Department of Health and the Minnesota Department of Human Services (DHS) meet about quarterly to discuss matters of mutual concern.

1. MCSHN Coordination

The following listing represents those areas in which the Minnesota Children with Special Health Needs (MCSHN) program (Title V) has some type of arrangement with the Department of Human Services (Title XIX).

- The MCSHN program is a Title XIX provider and is reimbursed for services provided to Title XIX-enrolled children.
- Through its Information and Referral 1-800 number, MCSHN staff assist families and providers in the identification of needs and in the determination of the most appropriate financial support available to meet those needs. Such financial support would include Medicaid, TEFRA (Medicaid eligibility for children who are disabled), the CAC (Community Alternative Care) and CADI (Community Alternatives for Disabled Individuals) waiver, and MinnesotaCare.
- The Department of Human Services provides the MCSHN program with on-line access to Title XIX reimbursement rates. These rates are used as the basis of MCSHN reimbursement to authorized providers.
- MCSHN uses the Department of Human Services automated claims payment system.
- MCSHN works with DHS regarding SSI data sharing and activities.
- MCSHN has ongoing relationships with Department of Human Services programs particularly MinnesotaCare and the Community Supports for Minnesotans with

Disabilities.

2. EPSDT Coordination and Standards

The Title V programs participate in the coordination of activities with the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program administered by the Minnesota Department of Human Services (DHS). Coordinated activities include the establishment of periodicity and content standards for EPSDT to assure that such programs are efficient and that current accepted medical practice standards are utilized. The current standards for EPSDT (known in Minnesota as Child and Teen Checkups) are contained in State Rules promulgated in June 1992 and include EPSDT periodicity and practice guidelines that closely mirror the AAP Guidelines for Health Supervision III. Recommendations for Preventative Pediatric Health Care, and HCFA recommendations related to TB, blood lead screening, and immunizations.

In the 2001 MDH/DHS contract, MDH Title V staff will provide DHS with support for EPSDT program development, quality assurance, capacity building, training and continuing education. (See Appendix J. for 2001 Interagency Agreement - EPSDT Contract). Meetings with DHS EPSDT staff and Maternal Child Health Section staff are scheduled on an ongoing basis to discuss contract related matters.

3. Medicaid Applicant Identification and Assistance

The MDH assures that both directly and through its grantees, arrangements will be maintained to identify pregnant women and infants who are eligible for Medical Assistance and assist them in applying. Local Maternal and Child Health Special Project grantees are required to document that they are maximizing Medical Assistance reimbursements to the extent available. They are encouraged as part of their grant applications to develop plans for outreach to high risk pregnant women, including pregnancy testing, and to assure that all components of prenatal care, appropriate to risk, are provided directly or through referrals to others for pregnant women enrolled in these programs. Referrals to Medical Assistance for eligibility determination are an aspect of this care coordination model.

C. Relationship with SSA, State Disabilities Determination Services unit and Vocational Rehab

The Minnesota Children with Special Health Care Needs (MCSHN) program has worked closely with the Social Security Administration (SSA) and Disability Determination Service (DDS) for many years. This relationship was developed to facilitate data and information sharing related to the SSI population in Minnesota. MCSHN currently receives a weekly data extract from the DDS containing data

on children under age 16 that have applied for Supplemental Security Income (SSI) benefits. This information is imported into the MCSHN Management Information System to generate a personal contact and for data collection purposes. MCSHN also recently reinstated, and analyzes a quarterly data extract from the SSA that will provide up-to-date information on all children currently receiving SSI benefits in Minnesota. MCSHN staff also meet on a quarterly basis with staff from DHS and SSA regarding updates and current SSI issues that need clarification.

4.3 Public Input

In Minnesota, opportunity for public input into the MCH planning process is ongoing, utilizing the variety of stakeholders and linkages described elsewhere in the application. A particularly significant source of input is provided by the state Maternal and Child Health Advisory Task Force. (See Section 1.5.1.2A. of this application for a description of the of the Task Force and its work plan.)

In past years, public hearings scheduled specifically to provide comments on the draft application process were not well attended. Accordingly, beginning in 1993 and continuing this year, the federally required public hearing has been conducted immediately following a regularly scheduled meeting of the state Maternal and Child Health Advisory Task Force. The meeting concerning this application was held on June 23, 2000.

This opportunity for public comment was publicized in a State Register Notice issued June 5, 2000 (See Appendix U.) and through direct mailings to Community Health Boards (See Appendix V. Community Health Services "Mail Bag" Announcement). A copy of the summary of the public hearing is found in Appendix W. Hearing on the Minnesota Application for FFY 2001 Maternal and Child Health Services Block Grant Public Meeting.

After transmittal, the application will be available upon request for public review and comment. As soon as feasible the application will also be included on the Department's web site.

4.4 Technical Assistance

Please see Form 15.

A. MCSHN Data Management

1. MCSHN currently tracks its treatment and evaluation population on a main-frame based program which was developed over twenty years ago. This system adequately maintains the data on the population but querying and cross-referencing is very difficult. Technical assistance to develop a methodology for evaluation information and data requirements for a new system is requested. It is estimated that this

assistance would cost $5,000 for 75 to 100 hours for a comprehensive review and recommendations.

B. MCSHN Web Page Redesign/Enhancement

2. A second MCSHN request is for consultation and recommendations for redesigning and enhancing the MCSHN web page. The plan is to improve links with other Minnesota programs and agencies involved with CSHN. This would include Part C, Department of Human Services, Department of Children and Family Learning, the University of Minnesota and other agencies.

C. Family Planning Quality Improvement

The Minnesota Department of Health staff, in conjunction with a workgroup comprised of interested stakeholders, has been re-examining the current allocation method for State funds appropriated for subsidized family planning services. To proceed further, technical assistance is needed to:

- assist with establishing performance objectives for the state level program and local grantee projects
- assist with developing clinical protocols to improve the quality of care provided by grantees
- assist with increasing the management efficience of local projects in order to improve service delivery

V. SUPPORTING DOCUMENTS

5.1 GLOSSARY

Adequate prenatal care - Prenatal care were the observed to expected prenatal visits is greater than or equal to 80% (the Kotelchuck Index).

Administration of Title V Funds - The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

Assessment - (see "Needs Assessment")

Capacity - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, "What does the State need to achieve the results we want?"

Capacity Objectives - Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for Children With Special Health Care Needs (CSHCN, see definition below) - those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. *[Title V Sec. 501(b)(3)*]

Carryover (as used in Forms 2 and 3) - The unobligated balance from the previous years MCH Block Grant Federal Allocation.

Case Management Services - For pregnant women - those services that assure access to quality prenatal,

delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. *(Title V Sec. 501(b)(4)*

Children -A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children With Special Health Care Needs (CSHCN) - *(For budgetary purposes)* Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. *(For planning and systems development)* - Those children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

Children With Special Health Care Needs (CSHCN) - Constructs of a Service System

1. State Program Collaboration with Other State Agencies and Private Organizations. States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.

2. State Support for Communities. State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development to assure that the unique needs of CSHCN are met.

3. Coordination of Health Components of Community-Based Systems. A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty

medical treatment services, mental health services, and home health care.

4. Coordination of Health Services with Other Services at the Community Level. A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Classes of Individuals - authorized persons to be served with Title V funds. See individual definitions under “Pregnant Women,” “Infants,” “Children with Special Health Care Needs,” “Children,” and “Others.”

Community - a group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-based Care - services provided within the context of a defined community.

Community-based Service System - an organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination (see Care Coordination Services)

Culturally Sensitive - the recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Culturally Competent - the ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

Deliveries - women who received a medical care procedure (were provided prenatal, delivery or postpartum care) associated with the delivery or expulsion of a live birth or fetal death.Direct Health Care Services - those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social

workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care, inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination of with Medicaid, WIC and educations. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

EPSDT - Early and Periodic Screening, Diagnosis and Treatment - a program for medical assistance recipients under the age of 21, including those who are parents. The program has a Medical Protocol and Periodicity Schedule for well-child screening that provides for regular health check-ups, vision/hearing/dental screenings, immunizations and treatment for health problems.
Family-centered Care - a system or philosophy of care that incorporates the family as an integral component of the health care system.

Federal (Allocation) (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) -The monies provided to the States under the Federal Title V Block Grant in any given year.

Government Performance and Results Act (GPRA) - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Health Care System - the entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

Infants - Children under one year of age not included in any other class of individuals.Infrastructure Building Services - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Jurisdictions - As used in the Maternal and Child Health block grant program: the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshal Islands, the Federated States of Micronesia and the Republic of Palau.

Kotelchuck Index - An indicator of the adquecy of prenatal care. See *Adequate Prenatal Care.*

Local Funding (as used in Forms 2 and 3) - Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low Income - an individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.[Title V, Sec. 501 (b)(2)]

MCH Pyramid of Health Services - (see “Types of Services”)

Measures - (see “Performance Measures”)

Needs Assessment - a study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is to aimed at determining: 1) What is essential in terms of the provision of health services; 2) What is available; and, 3) What is missing

Objectives - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also “Performance Objectives”)

Other Federal Funds (Forms 2 and 3) - Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, HIV/AIDs monies, CISS funds, MCH targeted funds from CDC and MCH Education funds.

Others (as in Forms 4, 7, and 10) - Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

Outcome Objectives - Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality

Outcome Measure - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, “Why does the State do our program?”

Performance Indicator - The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure - a narrative statement that describes a specific maternal and child health need, or

requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: "The rate of women in [State] who receive early prenatal care in 19__." This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

Performance Measurement - The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

Performance Objectives - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

Population Based Services - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

PRAMS - Pregnancy Risk Assessment Monitoring System - a surveillance project of the Centers for Disease Control and Prevention (CDC) and State health departments to collect State- specific, population-based data on maternal attitudes and experiences prior to, during, and immediately following pregnancy.

Pregnant Woman - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Preventive Services - activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care - the provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed

chronic health problems, and the overall management of an individual's or family's health care services.

Process - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, "Why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?"

Process Objectives - The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) - Funds collected by State MCH agencies from sources generated by the State's MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

Risk Factor Objectives - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

Risk Factors - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors
tend to be intermediate term. Risk factor results should answer the question, "Why should the State address this risk factor (i.e., what health outcome will this result support)?"

State - as used in this guidance, includes the 50 States and the 9 jurisdictions. (See also, Jurisdictions)

State Funds (as used in Forms 2 and 3) - The State's required matching funds (including overmatch) in any given year.

Systems Development - activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) - the process of providing recipients with expert assistance of specific health related or administrative services that include; systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration and, identification of core public health issues.

Title XIX, number of infants entitled to - The unduplicated count of infants who were eligible for the State's Title XIX (MEDICAID) program at any time during the reporting period.

Title XIX, number of pregnant women entitled to - The number of pregnant women who delivered during the reporting period who were eligible for the State's Title XIX (MEDICAID) program

Title V, number of deliveries to pregnant women served under - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

Title V, number of infants enrolled under - The unduplicated count of infants provided a direct service by the State's Title V program during the reporting period.

Total MCH Funding - All the MCH funds administered by a State MCH program which is made up of the sum of the *Federal* Title V Block grant allocation, the *Applicant's* funds (carryover from the previous year's MCH Block Grant allocation - the unobligated balance), the *State* funds (the total matching funds for the Title V allocation - match and overmatch), *Local* funds (total of MCH dedicated funds from local jurisdictions within the state), *Other* federal funds (monies <u>other</u> than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program), and *Program Income* (those collected by state MCH agencies from insurance payments, MEDICAID,

HMO’s, etc.).

Types of Services - The major kinds or levels of health care services covered under Title V activities. See individual definitions under “Infrastructure Building”, “Population Based Services”, “Enabling Services” and “Direct Medical Services”.

YRBS - Youth Risk Behavior Survey - A national school-based survey conducted annually by CDC and State health departments to assess the prevalence of health risk behaviors among high school students.

5.2 ASSURANCES AND CERTIFICATIONS

ASSURANCES -- NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have any questions, please contact the Awarding Agency. Further, certain federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. Sects. 4728-2763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88 Sect. 352) which prohibits discrimination on the

basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Sects. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sect. 794), which prohibits discrimination on the basis of handicaps; (d) The Age Discrimination Act of 1975, as amended (42 U.S.C. Sects 6101 6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office of Treatment Act of 1972 (P.L. 92-255), as amended, relating to non-discrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to non-discrimination on the basis of alcohol abuse or alcoholism; (g) Sects. 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. Sect. 3601 et seq.), as amended, relating to non-discrimination in the sale, rental, or financing of housing; (i) any other non-discrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other non-discrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. Sects 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. Sects. 276a to 276a-7), the Copeland Act (40 U.S.C. Sect 276c and 18 U.S.C. Sect. 874), the Contract Work Hours and Safety Standards Act (40 U.S.C. Sects. 327-333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable

construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sects. 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sects 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers systems.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. Sect. 470), EO 11593 (identification and preservation of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. Sects. 469a-1 et seq.)

14. Will comply with P.L.93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by the award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. Sects. 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply will all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

(a) are not presently debarred, suspended proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission or fraud or criminal judgment in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and
(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled “Certification Regarding Debarment, Suspension, In-eligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions” in all lower tier covered transactions (i.e. transactions with sub-grantees and/or contractors) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
(b) Establishing an ongoing drug-free awareness program to inform employees about-
(1) The dangers of drug abuse in the workplace;
(2) The grantee's policy of maintaining a drug-free workplace,
(3) Any available drug counseling, rehabilitation, and employee assistance programs; and
(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
(d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will-
(1) Abide by the terms of the statement; and
(2) Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
(e) Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted-
(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or
(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight
Office of Management and Acquisition
Department of Health and Human Services
Room 517-D
200 Independence Avenue, S.W.
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal,

amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also know as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by Federal

programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law doe not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.

5.3 OTHER SUPPORTING DOCUMENTS

Please see notes for ERP Forms 1-16

5.4 CORE HEALTH STATUS INDICATOR FORMS

5.5 CORE HEALTH STATUS INDICATOR DETAIL SHEETS

5.6 DEVELOPMENTAL HEALTH STATUS INDICATOR FORMS

5.7 DEVELOPMENTAL HEALTH STATUS INDICATOR DETAIL SHEETS

5.8 ALL OTHER FORMS

Please see Forms 2-15

5.9 NATIONAL "CORE" PERFORMANCE MEASURE DETAIL SHEETS

Please see SD CORE.1-SD CORE.18

and attachments - Performance Measure #2 & Performance Measure #14

5.10 STATE "NEGOTIATED" PERFORMANCE MEASURE DETAIL SHEETS

Please see Form 16 SD 16.1-SD 16.9

5.11 OUTCOME MEASURE DETAIL SHEETS

Please see SD CORE.19 - SD CORE .24

Appendix A.

ENDNOTES

1. Minnesota Historical Society. Collections of the Minnesota Historical Society. Volume 1. 1872. St. Paul. p.197.

2. U.S. Bureau of the Census. State Population Estimates and Demographic Components of Population Change July 1, 1998 to July 1, 1999. (1999, December 29). Washington, D.C. Population Estimates Program, Population Division. Retrieved February 7, 2000 from WWW. http://www.census.gov/population/estimates/state/st-99-1.txt

3. Minnesota Planning. Strong Population Growth Continues in Minnesota. (2000, February). St. Paul. State Demographic Center. Retrieved February 25, 2000 from WWW. http://www.mnplan.state.mn.us.

4. Ibid.

5. Ibid.

6. Ibid.

7. Ibid.

8. The nine counties and the percent of their 1990 population lost between 1990 and 1998 are: Big Stone (6.5%),Faribault (3.0%),Kittson (5.4%), Koochiching(2.9%), Lac qui Parle (4.3%), Lincoln (3.6%), Marshall (4.8%), Norman (4.3%)and Traverse (4.8%).

9. Minnesota Planning. Faces of the Future: Minnesota Population Projections 1995-2025. (1998, May)St. Paul. State Demographic Center. Retrieved February 22, 2000 from WWW. http://www.mnplan.state.mn.us

10. U.S. Bureau of the Census. Population Estimates for the U.S.,Regions, Divisions and States by 5-Year Age Groups and Sex: July 1, 1990 to July 1, 1998. (1999, June 15). Washington, D.C. Population Estimates Program. Retrieved February 21, 2000 from WWW. http://www.census.gov/population/estimates/state/5age9890.txt

11. Minnesota Planning. Faces of the Future

12. Minnesota Department of Children, Families and Learning. Gender and Ethnicity by District.(Web Release Date?) St. Paul. DCFL Data Center. Retrieved February 25, 2000 from www.http://cfl.state.mn.us/datactr/dtc_pdf.htm

13. Minnesota Planning. Trends in International Migration Continue. (Web Release Date?) St. Paul. State Demographic Center. Retrieved February 28, 2000 from WWW. http://www.mnplan.state.mn.us/demography/immigpb.html

14. Ibid.

15. Minnesota Planning. PopBites: Trends in International Migration Continue. (Web Release Date?). St. Paul. Retrieved February 21, 2000 from WWW. http://www.mnplan.state.mn.us

16. Ronningen, B.J. Estimates of Immigrant Populations in Minnesota. Working Paper 99-16. May, 1999. Minnesota Planning

17. U.S. Bureau of the Census. Model-Based Income and Poverty Estimates for Minnesota in 1995. (1999, February 17). Washington, D.C. Retrieved February 22, 2000 from WWW. http://www.census.gov/hhes/saipe/estimatecty/cty27000.htm

18. Ibid.

19. Minnesota Department of Human Services. Streamlining Eligibility: Minnesota's Experience. St. Paul. 1998.

20. Kennickell, A.B., Starr-McCluer, & Surette, B.J.(2000). Recent Changes in U.S. Family Finances: Results from the 1998 Survey of Consumer Finances. Federal Reserve Bulletin. Http://www.

21. Ibid.

22. Minnesota Department of Children, Families and Learning. Fall Populations by District [for 97-98 and 98-99 data]and Special Population by District [for 91-92 data] (Web Release Date?) St. Paul. DCFL Data Center. Retrieved February 25, 2000 from WWW. http://www.cfl.state.mn.us/datactr/dtc_pdf.htm

23. Ibid.

24. Minnesota Planning. Strong Population Growth Continues

25. Ibid.

26. Thiede-Call, K., et al. Minnesota Health Access Survey:1999 Minneapolis. October, 1999. Division of Health Services Research and Policy, School of Public Health, University of Minnesota.

27. Ibid.

28. Minnesota Department of Health. Health Care Coverage and Financing in Minnesota: Public Sector Programs. Health Economics Program. St. Paul. 1999.

29. U.S. Bureau of the Census. County Estimates for People of all Ages for Minnesota:1995. (1999,February). Washington, D.C. Retrieved March 13, 2000 from WWW. http://census.gov/cgi-bin/hhes/saipe/gettable.pls

30. Counties with the highest percentage of poverty among their residents include Mahnomen(18.9%), Beltrami (18.6%), Clearwater (17.9%), Wadena (16.0%), Cass (15.9%), Todd (15.1%), Aitkin (14.9%), Becker (14.9%), Norman (14.6%), Polk (14.1%), and Hubbard (14.0%).

31. Minnesota Department of Health. Populations of Color in Minnesota: Health Status Report. Office of Minority Health. St. Paul. 1997.

32. Minnesota Department of Children, Families and Learning. Minnesota Student Survey: 1989-1992-1995. Office of Community Collaboration. St. Paul. 1995.

33. U.S. Bureau of the Census, Current Population Reports,P60-200. Money Income in the United States:1997. U.S. Government Printing Office, Washington, D.C.1998.

34. See footnote 17 above.

35. Minnesota Department of Health. Center for Health Statistics. Unpublished data. Five year average (1994-98) state infant mortality rates for African Americans was 16.8, for American Indians it was 17.2 and for Whites it was 5.6.

36. Minnesota Department of Health. Populations of Color in Minnesota: Health Status Report. Office of Minority Health. St. Paul. 1997.

37. Minnesota Department Of Health. Center for Health Statistics.

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39. U.S. Bureau of the Census. Health Insurance Coverage. (2000, March 2). Washington, D.C. Retrieved March 15, 2000 from WWW. http://www.census.gov/hhes/hlthins/hlthin98.html

40. Minnesota Department of Health. Characteristics and Trends Among Minnesota's Uninsured Population. Health Economics Program. St. Paul. Prepublication Draft. 2000.

41. Theide-Call, K. Minnesota Health Access Survey: 1999. P.25.

42. Ibid.

43. Minnesota Department of Health. Distribution of Insurance Coverage: 1997.St. Paul. Health Economics Program. March, 1999.

44. Ibid.

45. Ibid.

46. During 1999 a total of 645,174 persons were enrolled at some point in one of the state's three publicly funded programs: 474,194 in MA; 130,998 in MinnesotaCare and 39,982 in GAMC. This compares to 647,664 persons enrolled at some point in 1998, of whom 473,129 were enrolled in MA, 124,789 in MinnesotaCare and 49,746 in GAMC. Personal communication from DHS, 1999 data as of April 1, 2000.

47. Minnesota Department of Human Services. Minnesota Health Care Programs. (Web Release Date?)St. Paul. Retrieved March 2, 2000 from WWW. http://www.dhs.state.mn.us/hlthcare/asstprog/mhcap.htm

48. Ibid.

49. Minnesota Department of Human Services. Minnesota Healthcare Programs Enrollment Figures. (2000, January.)St. Paul. Retrieved March 15, 2000 from WWW. http://dhs.state.mn.us/hlthcare/asstprog/enroll.htm

50. For a more detailed discussion of managed care, Minnesota's Medicaid program and its Section 1115 waiver history see: Minnesota Department of Human Services. Phase 2 of the MinnesotaCare Health Care Waiver: Minnesota Prepaid Medical Assistance Project Plus (PMAP+). 1998. St. Paul.

51. Minnesota Statutes, 1997 Supplement, Section 256B.69

52. Itasca and Ramsey are current PMAP+ counties that want to make the transition to CBP. Twenty-nine other counties in five groupings also wish to elect the CBP model and they are: Essential Health Plan (Cass, Crow Wing, Morrison, Todd and Wadena); North Central (Beltrami, Clearwater and Hubbard); Polk Care Plan (Polk); Prime West Health System (Grant, Douglas, Stevens, Pope, Meeker, McLeod, Renville, Traverse, Big Stone and Pipestone); South Country Health Plan (Kanabec, Brown, Sibley, Goodhue, Wabasha, Waseca, Steele, Dodge, Freeborn, and Mower).

53. Minnesota Statutes, Section 256.936

54. Minnesota Statutes, Section 256.9351

55. See footnote 46.

56. Minnesota Statutes, Section 2556B.05.

57. Minnesota Department of Health. Employer-Based Health Insurance in Minnesota. Health Economics Program. St. Paul. 2000.

58. Minnesota Statutes, Section 62Q.165, Subdivision 2.

59. Minnesota Department of Health. Distribution of Insurance Coverage: 1997

60. Minnesota Department of Health. Employer-Based Health Insurance. P. 49.

61. Minnesota Departent of Health. Strategic Directions. (Web Release Date?). St. Paul. Commissioner's Office. Retrieved February 28, 2000 @ http://www.health.state.mn.us

62. Minnesota Department of Health. Healthy Minnesotans-Public Health Improvement Goals: 2004. St. Paul. 1998.

63. Minnesota Department of Health. Strategies for Public Health: A Compendium of Ideas, Experience, and Research from Minnesota's Public Health Professionals. St. Paul. 1999.

64. Minnesota Statutes, Section 144.882

65. Minnesota Statutes, Section 145.881

66. Minnesota Statutes, Section 4.045

67. Minnesota Statutes, Section 245.487

68. Minnesota Statutes, Section 256F.13

69. Minnesota Statutes, Section 144.125

70. Mother's Survey, Ross Products Division of Abbott Laboratories

71. Minnesota Statutes, Section 145.19266, Subdivision 6.